211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS

52.01: Authority

211 CMR 52.00 is promulgated in accordance with authority granted to the Commissioner of Insurance by M.G.L. c. 175, § 24B, and M.G.L. c. 176O, §§ 2 and 17.

52.02: Applicability

211 CMR 52.00 applies to any carrier that offers for sale, provides or arranges for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employs utilization review in making decisions about whether services are covered benefits under a health benefit plan. A carrier that provides coverage for limited health care services only, that provides specified services through a workers' compensation preferred provider arrangement, or that does not provide services through a network or through participating providers shall be subject to those requirements of 211 CMR 52.00 as deemed appropriate by the Commissioner in a manner consistent with a duly filed application for accreditation as outlined in 211 CMR 52.06(2).

52.03: Definitions

As used in 211 CMR 52.00, the following words mean:

Accreditation, a written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

Administrative Disenrollment, a change in the status of an insured whereby the insured remains with the same carrier but his or her membership may appear under a different identification number. Examples of an administrative disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that may be recorded by the carrier as both a disenrollment and an enrollment.

Adverse Determination, a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Ambulatory Review, utilization review of health care services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency facility, as well as other locations such as laboratories, radiology facilities, provider offices and patient homes.

Authorized Representative, an insured's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to M.G.L. c. 210, family member, or other person authorized by the insured in writing or by law with respect to a specific grievance or external review provided that if the insured is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the

insured's representative or appoint another responsible party to serve as the insured's authorized representative.

Bureau of Managed Care or Bureau, the bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Capitation, a set payment per patient per unit of time made by a carrier to a licensed health care professional, health care provider group or organization that employs or utilizes services of health care professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Carrier shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

Case Management, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Clinical Peer Reviewer, a physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a nonrestricted license from the appropriate professional licensing board in Massachusetts, current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who actively practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Clinical Review Criteria, the written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a carrier to determine the medical necessity and appropriateness of health care services.

Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26 §6 or his or her designee.

Complaint, (a) any inquiry made by or on behalf of an insured to a carrier or utilization review organization that is not explained or resolved to the insured's satisfaction within three business days of the inquiry; or (b) any matter concerning an

adverse determination. In the case of a carrier or utilization review organization that does not have an internal inquiry process, a complaint means any inquiry.

Concurrent Review, utilization review conducted during an insured's inpatient hospital stay or course of treatment.

Covered Benefits or Benefits, health care services to which an insured is entitled under the terms of the health benefit plan.

Days, calendar days unless otherwise specified in 211 CMR 52.00; provided, that computation of days specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR 52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Discharge Planning, the formal process for determining, prior to discharge from a facility, the coordination and management of the care that an insured receives following discharge from a facility.

Division, the Division of Insurance.

Emergency Medical Condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Evidence of Coverage, any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an insured specifying the benefits to which the insured is entitled. For workers' compensation preferred provider arrangements, the evidence of coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)(1).

Facility, a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Finding of Neglect, a written determination by the Commissioner that a carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

Grievance, any oral or written complaint submitted to the carrier that has been initiated by an insured, or the insured's authorized representative, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 105 CMR 128.000 .

HMO, a health maintenance organization licensed pursuant to M.G.L. c. 176G.

Health Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health Care Professional, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

Health Care Provider or Provider, a health care professional or facility.

Health Care Services, or Health Services, services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Incentive Plan, any compensation arrangement between a carrier and licensed health care professional or licensed health care provider group or organization that employs or utilizes services of one or more licensed health care professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to insureds of the organization. "Incentive plan" shall not mean contracts that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with 211 CMR 52.00.

Inquiry, any communication by or on behalf of an insured to the carrier or utilization review organization that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of the carrier.

Insured, an enrollee, covered person, insured, member, policy holder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

JCAHO, the Joint Commission on Accreditation of Healthcare Organizations.

Licensed Health Care Provider Group, a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a licensed health care provider group only if it is composed of individual health care professionals and has no subcontracts with licensed health care provider groups.

Limited Health Service, dental care services, vision care services, pharmaceutical services, and such other services as may be determined by the Commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as such services are provided in conjunction with the limited health services set forth in the preceding sentence.

Managed Care Organization or MCO, a carrier subject to M.G.L. c. 176O.

Material Change, a modification to any of a carrier's procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier or health care provider.

Medical Necessity or Medically Necessary, health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) for services and interventions not in widespread use, is based on scientific evidence.

National Accreditation Organization, JCAHO, NCQA, URAC, or any other national accreditation entity approved by the Division that accredits carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

Network, a group of health care providers who contract with a carrier or affiliated carriers to provide health care services to insureds covered by any or all of the carrier's or affiliated carrier's plans, policies, contracts or other arrangements. Network shall not mean those participating providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

NCQA, the National Committee for Quality Assurance.

Nongatekeeper Preferred Provider Plan, an insured preferred provider plan approved for offer under M.G.L. c. 176I which offers preferred benefits when a covered person receives care from preferred network providers but does not require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level.

Office of Patient Protection, the office in the Department of Public Health established by M.G.L. c. 111, § 217(a).

Participating Provider, a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier.

Preventive Health Services, any periodic, routine, screening or other services designed for the prevention and early detection of illness that a carrier is required to provide pursuant to Massachusetts or federal law.

Prospective Review, utilization review conducted prior to an admission or a course of treatment. The term "prospective review" shall include any pre-authorization and pre-certification requirements of a carrier or utilization review organization.

Religious Non-Medical Provider, a provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Retrospective Review, utilization review of medical necessity that is conducted after services have been provided to a patient. The term "retrospective review" shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Second Opinion, an opportunity or requirement to obtain a clinical evaluation by a health care professional other than the health care professional who made the original recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Service Area, the geographical area as approved by the Commissioner within which the carrier has developed a network of providers to afford adequate access to members for covered health services.

Terminally Ill or Terminal Illness, an illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. section 1395x(dd)(3)(A).

URAC, the American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Utilization Review, a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization Review Organization, an entity that conducts utilization review under contract with or on behalf of a carrier, but does not include a carrier performing utilization review for its own health benefit plans.

52.04: Accreditation of Carriers

(1) A carrier must be accredited according to the requirements set forth in 211 CMR 52.00 in order to offer for sale, provide, or arrange for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employ utilization review in making decisions about whether services are covered benefits under a health benefit plan.
(2) Accreditation granted to carriers pursuant to 211 CMR 52.00 shall remain in effect for 24 months unless revoked or suspended by the Commissioner.
(3) A carrier shall be exempt from 211 CMR 52.00 if in the written opinion of the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health, the health and safety of health care consumers would be materially jeopardized by requiring accreditation of the carrier.

(a) Before publishing a written exemption pursuant to 211 CMR 52.04(3), the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited.
(b) A carrier granted an exemption pursuant to 211 CMR 52.04(3) shall be provisionally accredited and, during such provisional accreditation, shall be subject to review not less than every four months and shall be subject to those requirements of M.G.L. c. 176O and 211 CMR 52.00 as deemed appropriate by the Commissioner.
(c) Before the end of each four-month period specified in 211 CMR 52.04(3)(b) the Commissioner shall review the carrier's exemption.

1. If the Bureau determines that the carrier has met the requirements of 211 CMR 52.00, then the carrier shall be accredited and the exemption shall expire upon accreditation.
2. If the Commissioner determines that the carrier's exemption should be continued, the Commissioner shall communicate that determination in writing to the Attorney General and the Commissioner of Public Health. Continuation of the exemption shall be granted only upon a written decision by the Commissioner, the Attorney General and the Commissioner of Public Health.

52.05: Deemed Accreditation

(1) A carrier may apply for deemed accreditation. A carrier that applies for deemed accreditation may be deemed to be in compliance with the standards set forth in 211

CMR 52.00 and may be so accredited by the Bureau if it meets the following requirements:

(a) It must be accredited by JCAHO, NCQA or URAC;

(b) It must meet all the requirements set forth in M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000; and

(c) It must have received the ratings specified in 211 CMR 52.06(5)(c).

(2) For a carrier that applies for deemed accreditation,

(a) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(c), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.08 and 211 CMR 52.09 for that applicable period.

(b) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(d), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.10 for that applicable period.

(3) A carrier shall not be eligible for deemed accreditation status if the national accreditation organization has revoked the carrier's accreditation status in the past twenty-four months or the accreditation status of an entity that currently contracts with the carrier to provide services regulated by M.G.L. c. 176O.

(4) A carrier that has applied for deemed accreditation and that has been denied deemed accreditation shall be considered as an applicant for accreditation under 211 CMR 52.06(3) or 211 CMR 52.06(4). Denial of a request for deemed accreditation shall not be eligible for reconsideration under 211 CMR 52.07(5).

(5) If a carrier has received accreditation from a national accreditation organization or a carrier's subcontracting organization, with whom the carrier has a written agreement delegating certain services, has received accreditation or certification from a national accreditation organization, but under standards other than those identified in 211 CMR 52.06(5), the carrier may submit the documents indicating such accreditation or certification so that the Division may consider this in developing the scores described in 211 CMR 52.07(1).

52.06: Application for Accreditation

(1) Timing of Application.

(a) Beginning with renewal applications effective after August 1, 2002, carriers must submit renewal applications by July 1 for renewals to be effective on November 1.

(b) A carrier seeking initial accreditation after January 1, 2001 must submit an application at least 90 days prior to the date on which it intends to offer health benefit plans.

(2) Inapplicability of Accreditation Requirements.

(a) A carrier that provides coverage for limited health services only, that does not provide services through a network or through participating providers, or for which other requirements set forth in 211 CMR 52.06 are otherwise inapplicable may indicate within its application which of those items are inapplicable to its health benefit plan and provide an explanation of why the carrier is exempt from each particular requirement.

(b) A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(3)(b),(e),(g),(h),(i),(j),(l), and (n). A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(4)(d) and (g).

(3) Initial Application. Any carrier seeking initial accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts described in 211 CMR 52.06(3)(a) through (p) in a format specified by the Commissioner. Any carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of the materials from the contracting organization.

(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts:

(b) A complete description of the carrier's utilization review policies and procedures;

(c) A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;

(d) A copy of the most recent existing survey described in 211 CMR 52.08(9);

(e) A complete description of the carrier's internal grievance procedures consistent with 105 CMR 128.200 through 128.313 and the external review process consistent with 105 CMR 128.400 through 401;

(f) A complete description of the carrier's process to establish guidelines for medical necessity consistent with 105 CMR 128.101;

(g) A complete description of the carrier's quality management and improvement policies and procedures;

(h) A complete description of the carrier's credentialing policies and procedures.

(i) A complete description of the carrier's policies and procedures for providing or arranging for the provision of preventive health services;
(j) A sample of every provider contract used by the carrier or the organization with which the carrier contracts;
(k) A statement that advises the Bureau whether or not the carrier has issued new contracts, revised existing contracts, or after July 1, 2001, made revisions to fee schedules in any existing contract with a physician or physician group that impose financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider. If the carrier has made any of the specified changes, the carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(l) A copy of every provider directory used by the carrier;
(m) The evidence of coverage for every product offered by the carrier;
(n) A copy of each disclosure described in 211 CMR 52.14;
(o) A written attestation that the carrier has complied with 211 CMR 52.16; and
(p) Any additional information as deemed necessary by the Commissioner.

(4) Renewal Application. Any carrier seeking renewal of accreditation under M.G.L. c. 176O must submit an application that contains at least the materials for Massachusetts described in 211 CMR 52.06(4)(a) through (j) in a format specified by the Commissioner. Any carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of the materials from the contracting organization.

(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;
(b) A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
(c) A copy of the most recent survey described in 211 CMR 52.08(10);
(d) A sample of every provider contract used by the carrier or the organization with which the carrier contracts since the carrier's most recent accreditation;
(e) A statement that advises the Bureau whether or not the carrier has issued new contracts, revised existing contracts, or after July 1, 2001, made revisions to fee schedules in any existing contract with a physician or physician group that impose financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider. If the carrier has made any of the specified changes, the carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(f) The evidence of coverage for every product offered by the carrier that was revised since the carrier's most recent accreditation;
(g) A copy of the most recently revised provider directory used by the carrier;
(h) Material changes to any of the information contained in 211 CMR 52.06(3)(b), (e), (f), (g), (h), (i), and (n);
(i) Evidence satisfactory to the Commissioner that the carrier has complied with 211 CMR 52.16; and
(j) Any additional information as deemed necessary by the Commissioner.

(5) Application for Deemed Accreditation. A carrier seeking deemed accreditation pursuant to 211 CMR 52.05 shall submit an application that contains the following:

(a) For initial applicants, the information required by 211 CMR 52.06(3).

(b) For renewal applicants, the information required by 211 CMR 52.06(4).

(c) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the categories of utilization management, quality management and improvement, and members' rights and responsibilities;
2. a score equal to or above the rating of "accredited" in the categories of utilization management, network management, quality management and member protections for the most recent review of health plan standards by URAC; or
3. for nongatekeeper preferred provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of preferred provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.
4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the most recent review of health utilization management standards by URAC and a score equal or above the rating of "accredited" in the categories of network management, quality management and member protections for the most recent review of health network standards by URAC.

(d) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the category of credentialing and recredentialing;
2. a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health plan standards by URAC; or
3. for nongatekeeper preferred provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of preferred provider organizations in the category of credentialing and recredentialing.
4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health network standards by URAC.

(6) Application to be Reviewed as a Nongatekeeper Preferred Provider Plan. A carrier shall submit a statement signed by a corporate officer certifying that none of the carrier's insured plans require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level.

(7) Material Changes. Carriers shall submit material changes to any of the items required by 211 CMR 52.06(3) and 211 CMR 52.06(4) to the Bureau at least 30 days before the effective date of the changes.

52.07: Review of Application for Accreditation

(1) The Bureau shall review all applications for accreditation according to the standards set forth in M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

(a) For all products, except nongatekeeper preferred provider plans, a carrier shall not be accredited unless the carrier scores 65% or higher of all the elements described in *Appendix* A: 211 CMR 52.100, *Appendix* B: 211 CMR 52.101, and *Appendix* C: 211 CMR 52.102 for those requirements applicable to that carrier's health plans.

(b) For nongatekeeper preferred provider plans, a carrier shall not be accredited unless the carrier scores 65% or higher of all the elements described in *Appendix* D: 211 CMR 52.110, *Appendix* E: 211 CMR 52.111, and *Appendix* F: 211 CMR 52.112 for those requirements applicable to that carrier's health plans.

(c) In reviewing the carrier's application for accreditation under 211 CMR 52.07, the carrier may be given credit toward the relevant score for any accreditation that it received separately or a subcontracting organization, with whom the carrier has a written agreement delegating certain services, has received accreditation or certification from a national accreditation organization for the standards described in 211 CMR 52.08, 211 CMR 52.09 or 211 CMR 52.10.

(2) A carrier's application will not be considered to be complete until all materials required by M.G.L. c. 176O and 211 CMR 52.00 have been received by the Bureau. A carrier shall respond to any request for additional information by the Bureau within 15 days of the date of the Bureau's request. A carrier that fails to respond in writing to requests within the 15 days shall be subject to the penalties described in 211 CMR 52.17.

(3) The Bureau may schedule, at the carrier's expense, on-site surveys of the carrier's utilization review, quality management and improvement, credentialing and preventive health services activities in order to examine records. Any on-site visit shall be scheduled within 15 days of receipt of a carrier's complete application.

(4) The Bureau shall notify a carrier in writing that it is accredited or that its application for accreditation has been denied. If an accreditation is denied, the Bureau shall identify those items that require improvement in order to comply with accreditation standards.

(5) Reconsideration of a Denial.

(a) A carrier whose application for accreditation has been denied may make a written request to the Bureau for reconsideration within ten days of receipt of the Bureau's notice.

(b) The Bureau shall schedule a meeting with the carrier within ten days of the receipt of the request for reconsideration to review any additional materials presented by the carrier.
(c) Following the meeting pursuant to 211 CMR 52.07(5)(b) the Bureau may conduct a second on-site survey at the expense of the carrier.
(d) The Bureau shall notify a carrier in writing of the final disposition of its reconsideration.

52.08: Standards for Utilization Review

(1) Appendices. A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in *Appendix* A: 211 CMR 52.100. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards as set forth in *Appendix* D: 211 CMR 52.110. In addition, carriers shall meet the requirements identified in 211 CMR 52.08(2) through (10). In cases where the standards in 211 CMR 52.08(2) through (10) differ from those in 211 CMR 52.100, the standards in 211 CMR 52.08(2) through (10) shall apply.
(2) Written plan. Utilization review conducted by a carrier or utilization review organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to
(a) review and evaluate its effectiveness,
(b) ensure the consistent application of utilization review criteria, and
(c) ensure the timeliness of utilization review determinations.
(3) Criteria. A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities pursuant to said criteria.
(a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria consistent with 105 CMR 128.101.
(b) Utilization review criteria shall be applied consistently by a carrier or utilization review organization.
(c) Adverse determinations rendered by a program of utilization review, or other denials of requests for health services, shall be made by a person licensed in the appropriate specialty related to such health service and, where applicable, by a provider in the same licensure category as the ordering provider, and shall explain the reason for any denial, including the specific utilization review criteria or benefits provisions used in the determination, and all appeal rights applicable to the denial.
(4) Initial Determination Regarding a Proposed Admission, Procedure or Service. A carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information.

(a) For purposes of 211 CMR 52.08(4), "necessary information" shall include the results of any face-to-face clinical evaluation or second opinion that may be required.

(b) In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter.

(c) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter.

(5) Concurrent Review. A carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information.

(a) In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify the provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(b) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the insured and the provider within one working day thereafter.

(c) The service shall be continued without liability to the insured until the insured has been notified of the determination.

(6) Written notice. The written notification of an adverse determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

(a) identify the specific information upon which the adverse determination was based;

(b) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify any alternative treatment option offered by the carrier, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) include a clear, concise and complete description of the carrier’s formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400.

(7) Reconsideration of an Adverse Determination. A carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination.

(a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one working day.

(b) If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to 105 CMR 128.000.

(c) The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to the internal grievance process or an expedited appeal required by 105 CMR 128.000.

(8) Continuity of care. A carrier must provide evidence that its policies regarding continuity of care comply with all provisions of 105 CMR 128.500 through 128.503.

(9) Workers' compensation preferred provider arrangement. A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.08, except 211 CMR 52.08(9), if it has met the requirements of 452 CMR 6.00.

(10) Annual survey. A carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of insureds with projected measures of their satisfaction.

(b) Carriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds.

(11) Religious non-medical treatment and providers. Nothing in 211 CMR 52.08 shall be construed to require health benefit plans to use medical professionals or criteria to decide insured access to religious non-medical providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by religious non-medical providers, compel an insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious non-medical provider, or require health benefit plans to exclude religious non-medical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the provider.

52.09: Standards for Quality Management and Improvement

(1) Appendices. A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in 211 CMR 52.101 *Appendix* B. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in 211 CMR 52.111 *Appendix* E.

(2) Workers' Compensation Preferred Provider Arrangements. A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.09 if it has met the requirements of 452 CMR 6.00.

52.10: Standards for Credentialing

(1) A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in 211 CMR 52.102 *Appendix* C. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in 211 CMR 52.112 *Appendix* F.
(2) A carrier shall provide a written reason or reasons for denial to health care providers whose applications to be participating providers were denied.
(3) A carrier shall not be required to meet the requirements of 211 CMR 52.10 if the carrier does not provide benefits through a network or does not have contracts with participating providers.
(4) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.10 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.11: Standards for Preventive Health Services

(1) A carrier's application will be reviewed for compliance with preventive services mandated by applicable law. A carrier that is not an HMO shall be required to comply with 211 CMR 52.11 only to the extent of those preventive health services mandated by its licensing or enabling statute.
(2) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.11.

52.12: Standards for Provider Contracts

(1) Contracts between carriers and health care providers shall state that a carrier shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or

(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient.

(2) Contracts between carriers and health care providers shall state that the provider is not required to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.
(3) No contract between a carrier and a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care

professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract.

(a) Health care professionals shall not profit from provision of covered services that are not medically necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with 211 CMR 52.12(4).

(4) No carrier may enter into a new contract, revise the risk arrangements in an existing contract, or after July 1, 2001, revise the fee schedule in an existing contract with a physician or physician group which imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection,

(b) minimum patient population size for the physician or physician group, and

(c) identification of the health care services for which the physician or physician group is at risk.

(5) Contracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause.

(6) Contracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

(7) Contracts between carriers and health care providers shall state that the carrier shall notify providers in writing of modifications in payments, modifications in covered services or modifications in a carrier’s procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider.

(8) Contracts between carriers and health care providers shall state that providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

(9) Contracts between carriers and health care providers shall prohibit health care providers from billing patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

(10) Contracts between carriers and health care providers shall require providers to comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
(11) Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.
(12) Nothing in 211 CMR 52.12 shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

52.13: Evidences of Coverage

(1) A carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment, an evidence of coverage. The evidence of coverage shall contain a clear, concise and complete statement of:

(a) the health care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law;
(b) the prepaid fee which must be paid by or on behalf of the insured and an explanation of any grace period for the payment of any premium;
(c) the limitations on the scope of health care services and any other benefits to be provided, including an explanation of any deductible or copayment feature;
(d) all restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health benefit plan;
(e) the locations where, and the manner in which, health care services and other benefits may be obtained;
(f) a description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;
(g) the criteria by which an insured may be disenrolled or denied enrollment;
(h) the involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.13(1)(h), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.
2. For the purposes of 211 CMR 52.13(1)(h), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(1)(i)2. and 3.

(i) the requirement that an insured's coverage may be canceled, or its renewal refused, only in the following circumstances:

1. failure by the insured or other responsible party to make payments required under the contract;
2. misrepresentation or fraud on the part of the insured;
3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of this clause;
4. relocation of the insured outside the service area of the carrier; or
5. non-renewal or cancellation of the group contract through which the insured receives coverage;

(j) a description of the carrier's method for resolving insured inquiries and complaints, including a description of the internal grievance process consistent with 105 CMR 128.300 through 128.313, and the external review process consistent with 105 CMR 128.400 through 128.416;
(k) a statement telling insureds how to obtain the report regarding grievances pursuant to 105 CMR 128.600(A)(4) from the Office of Patient Protection;
(l) a description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and internet site;
(m) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers;
(n) a summary description of the utilization review procedures and quality assurance programs used by the carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions;
(o) a statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish;
(p) a list of prescription drugs excluded from any closed or restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary.

1. A carrier will be deemed to have met the requirements of 211 CMR 52.13(1)(p) if the carrier does all of the following:
   a. provides a complete list of prescription drugs that are included in any closed or restricted formulary;
   b. clearly states that all other prescription drugs are excluded;
   c. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and
   d. provides an internet site that is updated as soon as practicable relative to any change in the closed or restricted

formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

(q) a summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(r) requirements for continuation of coverage mandated by state and federal law;

(s) a description of coordination of benefits consistent with 211 CMR 38.00;

(t) a description of coverage for emergency care and a statement that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(u) If the carrier offers services through a network or through participating providers, the following statements regarding continued treatment:

1. If the carrier allows or requires the designation of a primary care physician, a statement that the carrier will notify an insured at least 30 days before the disenrollment of such insured's primary care physician and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care physician for at least 30 days after said physician is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative primary care physician.

2. A statement that the carrier will allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

3. A statement that the carrier will allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

4. A statement that the carrier will provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a physician who is not a participating provider in the carrier's network if:

a. the insured's employer only offers the insured a choice of carriers in which said physician is not a participating provider, and

b. said physician is providing the insured with an ongoing course of treatment or is the insured's primary care physician.

c. With respect to an insured in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision shall apply to services rendered until death.

5. A carrier may condition coverage of continued treatment by a provider under 211 CMR 52.13(1)(u)1 through 52.13(1)(u)4, inclusive, upon the provider's agreeing as follows:

a. to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;

b. to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and

c. to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier.

6. Nothing in 211 CMR 52.13(1)(u) shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(v) If a carrier requires an insured to designate a primary care physician, a statement that the carrier will allow the primary care physician to authorize a standing referral for specialty health care provided by a health care provider participating in the carrier's network when:

1. the primary care physician determines that such referrals are appropriate,

2. the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care physician with all necessary clinical and administrative information on a regular basis, and

3. the health care services to be provided are consistent with the terms of the evidence of coverage.

4. Nothing in 211 CMR 52.13(v) shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(w) If a carrier requires an insured to obtain referrals or prior authorization from a primary care physician for specialty care, a statement that the carrier will not require an insured to obtain a referral or prior authorization from a primary care physician for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network and that the carrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care physician:

1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination;
2. maternity care; and
3. medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions.
4. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an insured's primary care physician regarding the insured's condition, treatment, and need for follow-up care.
5. Nothing in 211 CMR 52.13(1)(w) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(x) A statement that the carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.13(1)(x), mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services.

(2) A carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health plan at least 60 days before the effective date of the modifications. The notices shall include the following:

(a) any changes in clinical review criteria

(b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

(3) A carrier shall submit all evidences of coverage to the Division at least 30 days prior to their effective dates.

(4) A carrier shall provide to at least one adult insured in each household residing in Massachusetts notice of all material changes to the evidence of coverage.

(5) Carriers may use evidences of coverage issued prior to July 1, 2001, as if in compliance with 211 CMR 52.13. Evidences of coverage issued or renewed on or after July 1, 2001 must comply with all of the requirements of 211 CMR 52.13. Carriers shall issue to at least one adult insured in each household whose coverage renews between July 1, 2001, and June 30, 2002, an evidence of coverage upon renewal that complies with 211 CMR 52.13. Carriers may provide notice of material changes by issuing riders, amendments or endorsements to insureds who have received evidences of coverage in compliance with 211 CMR 52.13, provided, that a completely revised evidence of coverage shall be issued to at least one adult insured in each household residing in Massachusetts at least once every five years.

(6) Every evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

(7) A carrier will be deemed to have met the requirements to issue or deliver an evidence of coverage or any material change to an evidence of coverage to persons enrolled in an employer group plan when sending documents by electronic media, if:

(a) the employer group's insureds have the ability to effectively access documents furnished in electronic form at their worksite location;

(b) the employer group's insureds have the opportunity to readily convert furnished documents from electronic form to paper form free of charge at their worksite location;

(c) the carrier can demonstrate that it has taken appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt by insureds of the electronically transmitted information and documents (for example, the carrier uses the return-receipt electronic mail features or conducts periodic reviews or surveys to confirm receipt of transmitted information);

(d) the carrier can demonstrate that its electronically delivered documents are prepared and furnished in a manner consistent with that used for its paper documents;

(e) the carrier can demonstrate that the person covered through the employer group is provided notice, through electronic means or in writing, apprising the person of the documents to be furnished electronically, the significance of the documents and the person's right to request and method to receive, free of charge, a paper copy of such document; and

the carrier can demonstrate that it has taken the steps to furnish, upon request of the insured, a paper copy of any document delivered to the insured through electronic media.

(8) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.13 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.14: Required Disclosures

(1) A carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:

(a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;

(b) a summary description of the process by which clinical guidelines and utilization review criteria are developed;

(c) the voluntary and involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.14(1)(c), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area,

insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an insured has terminated coverage with the carrier for nonpayment of premium.

3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(1)(i)2. and 3.

(d) A notice to insureds regarding emergency medical conditions that states all of the following:

1. that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

2. that no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and

4. if the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.

(e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.16 is available to the insured or prospective insured from the Office of Patient Protection.

(2) The information required by 211 CMR 52.14 may be contained in the evidence of coverage and need not be provided in a separate document.

(3) Every disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date.

(4) Carriers shall submit material changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 days before their effective dates.

(5) Carriers shall submit material changes to the disclosures required by 211 CMR 52.14 to at least one adult insured in every household residing in Massachusetts at least once every two years.

(6) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.14 if it has met the requirements of 211 CMR 112.00 and 452 CMR 6.00.

52.15: Provider Directories

(1) A carrier shall provide a provider directory to at least one adult insured in each household upon enrollment and to a prospective or current insured upon request. Annually, thereafter, a carrier shall provide to at least one adult insured in each household, or in the case of a group policy, to the group representative, a provider directory.

(a) The provider directory must contain a list of health care providers in the carrier's network available to insureds residing in Massachusetts, organized by specialty and by location and summarizing for each such provider the method used to compensate or reimburse such provider.

1. Nothing in 211 CMR 52.15(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a carrier and a provider.

2. A carrier will be deemed to be in compliance with 211 CMR 52.15(1)(a) if the method of compensation is identified at least as specifically as "fee-for service" or "capitation."

3. If any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner.

(b) The provider directory must contain a toll-free number that insureds can call to determine whether a particular health care provider is affiliated with the carrier.

(c) The provider directory must contain an internet website address that insureds can visit to determine whether a particular provider is affiliated with the carrier.

(2) Carriers that issued provider directories prior to January 1, 2001 shall be deemed to have met the requirements of 211 CMR 52.15(1) if during the year between July 1, 2001 and June 30, 2002 the carrier delivers a provider directory to at least one adult insured in each household and to any new enrollee on or after July 1, 2001.

(3) A carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the carrier provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the provider directory originally provided under 211 CMR 52.15(1), and updates its toll-free number within 48 hours and internet website as soon as practicable A carrier shall not be required to provide a provider directory upon enrollment if a provider directory is provided to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

(4) Every provider directory described in 211 CMR 52.15 must contain the effective date, date of issue and expiration date if applicable.

(5) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.15 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.16: Material to be Provided to the Office of Patient Protection

A carrier shall provide the following to the Office of Patient Protection by no later than May 15:

(1) A copy of every evidence of coverage and amendments thereto offered by the carrier.

(2) A copy of the provider directory described in 211 CMR 52.15.

(3) A copy of the materials specified in 211 CMR 52.14.

(4) A list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by the carrier.

(5) A report of the percentage of physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous two calendar years for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;

(a) For the purposes of 211 CMR 52.16(5) carriers shall exclude physicians who have moved from one physician group to another but are still under contract with the carrier.

(b) For the purposes of 211 CMR 52.16(5) "voluntarily terminated" means that the physician terminated its contract with the carrier.

(c) For the purposes of 211 CMR 52.16(5) "involuntarily terminated" means that the carrier terminated its contract with the physician.

(6) The percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent two years for which information is available; and

(7) A report detailing, for the previous two calendar years, the total number of

(a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and

(b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such insureds, which shall include, but need not be limited to, race, gender and age.

(8) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.16(1), (2), (3), (6) and (7).

52.17: Noncompliance with 211 CMR 52.00

(1) Reporting. If the Commissioner issues a finding of neglect on the part of a carrier, the Commissioner shall notify the carrier in writing that the carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the carrier $5000 for each day during which the neglect continues.

(a) Following notice and hearing, the Commissioner shall suspend the carrier's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect can be removed.

(2) Noncompliance with Accreditation Standards Set Forth in 211 CMR 52.00.

(a) The Bureau shall investigate all complaints made against a carrier or any entity with which it contracts for allegations of noncompliance with the accreditation requirements established under 211 CMR 52.00.

(b) The Bureau shall notify a carrier when, in the opinion of the Bureau, complaints made against a carrier or any entity with which it contracts indicate a pattern of noncompliance with a particular requirement. The notice shall detail the alleged noncompliance and establish a hearing date for the matter.

(c) Hearing Held Pursuant to 211 CMR 52.17(2)(b).

1. The hearing shall be held no later than 21 days following the date of the notice specified in 211 CMR 52.17(2)(b).
2. The hearing shall be conducted pursuant to M.G.L. c. 30A.
3. The hearing shall provide the carrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.17(2)(c), the Bureau may issue a finding against the carrier, including but not limited to:

1. An order requesting a corrective action plan and timeframe to achieve compliance.
2. A reprimand or censure of the carrier.
3. A penalty not to exceed $10,000 for each classification of violation.
4. The suspension or revocation of the carrier's accreditation.

(3) Action by a National Accreditation Organization. If a national accreditation organization takes any action to revoke the accreditation or otherwise limit or negatively affect the accreditation status of a carrier, or any entity with which a carrier contracts for services subject to M.G.L. c. 176O, the carrier must notify the Bureau within two days and shall specify the action taken and the reasons given by the national accreditation organization for such action.

(4) If the national accreditation organization revokes accreditation, the Bureau shall initiate proceedings pursuant to M.G.L. c. 30A to revoke or suspend the carrier's accreditation.

(5) Nothing in 211 CMR 52.17 shall be construed to prohibit the Bureau and a carrier from resolving compliance issues through informal means.

52.18: Severability

If any provision of 211 CMR 52.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 52.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

Regulatory Authority
211 CMR 52.00: M.G.L. c. 175, §24B and c. 176O, §§2 and 17.

52.100: Appendix A: Standards and Guidelines for the Accreditation of MCOs: Utilization Management effective July 1, 2004

UM 1: Utilization Management Structure 0.40 points

The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.

Element A: Written Program Description 0.10 points

The organization's UM program description includes the following factors:

1. program structure.
2. behavioral health care aspects of the program.
3. involvement of a designated senior physician in UM program implementation.
4. involvement of a designated behavioral health care practitioner in the implementation of the behavioral health care aspects of the UM program.
5. scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.

Element B: Physician Involvement 0.10 points

A senior physician is actively involved in implementing the organization's UM program.

Element C: Behavioral Health Involvement 0.10 points

A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the UM program.

Element D: Annual Evaluation 0.10 points

The organization annually evaluates and updates the UM program, as necessary.

UM 2: Clinical Criteria for UM Decisions 2.00 points

To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.

Element A: UM Criteria 0.80 points

The organization:

1. has written UM decision-making criteria that are objective and based on medical evidence.
2. has written policies for applying the criteria based on individual needs.
3. has written policies for applying the criteria based on an assessment of the local delivery system.
4. involves appropriate practitioners in developing, adopting and reviewing criteria.
5. has a process for annually reviewing and updating UM criteria and the procedures for applying them.

Element B: Availability of Criteria 0.60 points

The organization:

1. states in writing how practitioners can obtain UM criteria.
2. makes the criteria available to its practitioners upon request.

Element C: Consistency in Applying Criteria 0.60 points

The organization annually evaluates the consistency with which health care professionals involved in UM apply criteria in decision making and acts on opportunities for improvement, if applicable.

UM 3: Communication Services 0.20 points

The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

Element A: Access to Staff 0.20 points

The organization provides the following communication services for practitioners and members:

1. availability of staff at least eight hours a day during normal business days for inbound calls regarding UM issues.
2. ability of staff to receive inbound communication after normal business hours regarding UM issues.
3. outbound communication from staff regarding inquiries about UM during normal business hours, unless otherwise agreed upon.
4. staff identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues.
5. a toll-free number or staff that accept collect calls regarding UM issues.
6. access to staff for callers with questions about the UM process.

UM 4: Appropriate Professionals 1.40 points

Qualified licensed health professionals assess the clinical information used to support UM decisions.

Element A: Licensed Health Professionals 0.30 points

The organization has written procedures:

1. requiring appropriately licensed professionals to supervise all medical necessity decisions.
2. specifying the type of personnel responsible for each level of UM decision making.

Element B: Use of Practitioners for UM Decisions 0.30 points

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity that requires:

1. education, training or professional experience in medical or clinical practice.
2. a current license to practice without restriction.

Element C: Practitioner Review of Non-Behavioral Health Denials 0.30 points

The organization ensures that a physician, dentist or pharmacist, as appropriate, reviews any non-behavioral health denial based on medical necessity.

Element D: Practitioner Review of Behavioral Health Denials 0.30 points
The organization ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.

Element E: Use of Board-Certified Consultants 0.20 points
The organization has written procedures for using board-certified consultants to assist in making medical necessity determinations.

UM 5: Timeliness of UM Decisions 2.00 points
The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

Element A: Timeliness of Non-Behavioral Health UM Decision Making 0.50 points
The organization adheres to the following standards for timeliness of UM decision making:

1. for nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.
2. for urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request.
3. for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.
4. for postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Element B: Notification of Non-Behavioral Health Decisions 0.50 points
The organization adheres to the following standards for notification of non-behavioral health UM decision making:

1. for nonurgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request.
2. for urgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.
3. for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request.
4. for postservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.

Element C: Timeliness of Behavioral Health UM Decision Making 0.50 points

The organization adheres to the following standards for timeliness of behavioral health UM decision making:

1. for nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.
2. for urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request.
3. for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.
4. for postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Element D: Notification of Behavioral Health Decisions 0.50 points

The organization adheres to the following standards for notification of behavioral health UM decision making:

1. for nonurgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request.
2. for urgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.
3. for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request.
4. for postservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.

UM 6: Clinical Information 1.10 points

When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating physician.

Element A: Information for UM Decision Making 0.30 points

The organization has a written description that identifies the information needed to support UM decision making in place for at least 12 months.

Element B: Procedures for Onsite Facility Reviews 0.10 points

If the organization provides onsite review services at facilities, it has a documented process that includes:

1. guidelines for identification of organization staff at the facility, in accordance with facility procedures.
2. a process for scheduling the onsite review in advance, unless otherwise agreed upon.
3. a process for ensuring that staff follow facility rules.

Element C: Documentation of Non-Behavioral Health Information 0.40 points

There is documentation that relevant clinical information is gathered consistently to support non-behavioral health UM decision making.

Element D: Documentation of Behavioral Health Information 0.20 points
There is documentation that relevant clinical information is gathered consistently to support behavioral health UM decision making.

Element E: Transition to Other Care 0.10 points
The organization assists with a member's transition to other care, if necessary, when benefits end.

UM 7: Denial Notices 1.50 points
The organization clearly documents and communicates the reasons for each denial.

Element A: Notification of Reviewer Availability 0.10 points
The organization notifies practitioners of:
1. its policy for making a reviewer available to discuss any UM denial decision.
2. how to contact the reviewer.

Element B: Discussing a Denial With a Reviewer 0.30 points
The organization provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or other appropriate reviewer.

Element C: Reason for Non-Behavioral Health Denial 0.30 point
The organization provides written notification of the non-behavioral health denial that contains the following:
1. the specific reasons for the denial, in easily understandable language.
2. a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.
3. notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

Element D: Non-Behavioral Health Notice of Appeals Rights/Process 0.30 points
The organization provides written notification of the non-behavioral health denial that contains the following:
1. description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
2. explanation of the appeal process, including the right to member representation and time frames for deciding appeals
3. if a denial is an urgent preservice or urgent concurrent denial, a description of the expedited appeal process.

Element E: Discussing a Behavioral Health Denial With a Reviewer 0.10 points

The organization provides practitioners with the opportunity to discuss any behavioral health UM denial decision with a physician, appropriate behavioral health or pharmacist reviewer.

Element F: Reason for Behavioral Health Denial 0.20 points

The organization provides written notification of the behavioral health denial that contains the following:

1. the specific reasons for the denial, in easily understandable language.
2. a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.
3. notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

Element G: Behavioral Health Notice of Appeals Rights/Process 0.20 points

The organization provides written notification of the behavioral health denial that contains the following:

1. description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
2. explanation of the appeal process, including the right to member representation and time frames for deciding appeals.
3. if a denial is an urgent preservice or urgent concurrent denial, a description of the expedited appeal process.

UM 8: Policies for Appeals 0.90 points

The organization has written policies and procedures for thorough, appropriate and timely resolution of member appeals.

Element A: Policies and Procedures 0.10 points

The organization has written policies and procedures in place for registering and responding to:

1. preservice appeals
2. postservice appeals
3. expedited appeals
4. external appeals.

Element B: Preservice Appeals 0.20 points

The organization's written policies and procedures for registering and responding to written preservice appeals include the following factors:

1. allowance of at least 180 days after notification of the denial for the member to file an appeal
2. documentation of the substance of a preservice appeal and any actions taken
3. full investigation of the substance of the appeal, including any aspects of clinical care involved
4. the opportunity for the member to submit written comments, documents or other information relating to the appeal

5. the appointment of a new person to review a preservice appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination
6. the appointment of at least one person to review a preservice appeal who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment (this applies to medical necessity appeals only)
7. the decision of the preservice appeal and notification to the member within 30 calendar days of receipt of the request
8. notification to the member about further appeal rights
9. procedures for providing to the member upon request, access to and copies of all documents relevant to the member's appeal
10. procedures for allowing an authorized representative to act on behalf of the member
11. procedures for expedited preservice appeals, which include the initiation, decision and notification process.

Element C: Postservice Appeals 0.20 points

The organization's written policies and procedures for registering and responding to written postservice appeals include the following factors:

1. allowance of at least 180 days after notification of the denial for the member to file an appeal.
2. documentation of the substance of postservice appeals and actions taken.
3. full investigation of the substance of the appeal, including any aspects of clinical care involved.
4. the opportunity for the member to submit written comments, documents or other information relating to the appeal.
5. the appointment of a new person to review postservice appeals who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
6. the appointment of at least one person to review postservice appeals who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment (this applies to medical necessity appeals only).
7. the decision of the postservice appeal and notification to the member within 60 calendar days of receipt of the request.
8. notification to the member about further appeal rights.
9. procedures for providing to the member, upon request, access to and copies of all documents relevant to the member's appeal.
10. procedures for allowing an authorized representative to act on behalf of the member.

Element D: External Reviews in States Without Laws 0.10 points

The organization's written policies and procedures for providing independent, external review of final determinations includes the following factors:

1. eligibility criteria stating that the organization offers members the right to an independent, third-party, binding review for all medical necessity denials.
2. a general communication to members announcing the availability of the right to independent review, at least annually.
3. a specific written or electronic notification to members of the independent appeal rights and processes, including contact information for the independent review organization (IRO), for eligible internal appeals that are denied.
4. a thorough review by the IRO in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence and makes a decision that is not bound by the decisions or conclusions of the internal appeal.
5. the IRO has no material professional, familial or financial conflicts of interest with the organization.
6. the organization must not attempt to interfere with the IRO's proceedings or appeal decision.
7. the member is not required to bear costs of the IRO, including any filing fees.
8. the member or the member's legal guardian may designate, in writing, a representative to act on the member's behalf.
9. notification to members of the IRO decision, including the time and procedure for claim payment or approval of service, in the event the IRO overturns the organization's decision.
10. the organization implements the IRO's decision within the time frame specified by the IRO.
11. the organization maintains or obtains from the IRO data on each appeal case and uses this information in evaluating its medical necessity decision-making process.

Element E: External Reviews in States With Laws 0.20 points

The organization's written policies and procedures for providing independent, external review of final determinations include the following required factors:

1. general communication to members announcing the availability of the right to independent review, at least annually.
2. for eligible internal appeals where the determination is adverse to the member, specific written or electronic notification to members of the independent appeal rights and processes, including contact information for the IRO.

Element F: Time Elements Are in Place 0.10 points

The organization's policies and procedures for handling appeals are in place for at least 12 months.

UM 9: Appropriate Handling of Appeals 3.50 points
The organization adjudicates member appeals in a thorough, appropriate and timely manner.

Element A: Preservice and Postservice Appeals 0.50 points
An NCQA review of the organization's appeal files indicates that there is:
1. documentation of the substance of appeals.
2. investigation of appeals.

Element B: Timeliness of the Appeal Process 0.50 points
Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frame:
1. the organization resolves preservice appeals within 30 calendar days of receipt of the request.
2. the organization resolves postservice appeals within 60 calendar days of receipt of the request.
3. the organization resolves expedited appeals within 72 hours of the request.

Element C: Appeal Reviewers 0.50 points
The organization provides for nonsubordinate reviewers who were not involved in the previous determination and same/similar specialist review, as appropriate.

Element D: Notification of Appeal Decision/Rights 0.50 points
An NCQA review of the organization's internal appeal files indicates notification to member of:
1. the specific reasons for the appeal decision in easily understandable language.
2. a reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
3. notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
4. notification that the member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the member's appeal.
5. a list of titles and qualifications of individuals participating in the appeal review.
6. a description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.

Element E: Appropriate Handling of Appeals 0.50 points
An NCQA review of the organization's internal appeal files indicates appropriate handling of appeals.

Element F: Final Internal and External Appeal Files 0.50 points
In an NCQA review of denials overturned by the IRO or of the organization's final internal

denials the files included:

1. member notification of independent appeal rights.
2. member notification about obtaining more information regarding independent appeal rights.
3. a statement that members are not required to bear costs of the independent review organization, including any filing fees.

Element G: Appeals Overturned by the IRO 0.50 points

In an NCQA review of the organization's files of appeals overturned by the IRO, there was evidence that the organization implemented the IRO's decision in all cases reviewed.

UM 10: Evaluation of New Technology 1.50 points

The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals and devices.

Element A: Written Process 0.50 points

The organization's written process for evaluating new technologies and the new application of existing technologies for inclusion in its benefits plan includes an evaluation of the following factors:

1. medical procedures.
2. behavioral health procedures.
3. Pharmaceuticals.
4. devices.

Element B: Description of the Evaluation Process 0.60 points

The organization's written evaluation process includes the following factors:

1. the process and decision variables the organization uses to make determinations
2. a review of information from appropriate government regulatory bodies
3. a review of information from published scientific evidence
4. a process for seeking input from relevant specialists and professionals who have expertise in the technology.

Element C: Evaluated New Technology Implementation 0.40 points

The organization implements a decision on coverage from its assessment of new technologies and new applications of existing technologies or from review of special cases.

UM 11: Satisfaction With the UM Process 2.50 points

The organization evaluates member and practitioner satisfaction with the utilization management process.

Element A: Assessing Satisfaction With the UM Process 2.50 points

The organization's evaluation of satisfaction with the UM process includes the following factors:

1. the use of information from members regarding their satisfaction with the UM process

2. the use of information from practitioners regarding their satisfaction with the UM process
3. gathering information about satisfaction with the UM process at least annually
4. taking strong action to address opportunities for improvement identified from information gathered about satisfaction with the UM process

UM 12: Emergency Services 1.50 points

The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.

Element A: Policies and Procedures 0.50 points

The organization's emergency services policies and procedures require:

1. coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed
2. coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency services.

Element B: Review of Presenting Symptoms 0.50 points

A physician or other appropriate practitioner reviews presenting symptoms as well as the discharge diagnosis for emergency services.

Element C: Organization's Authorized Representative 0.50 points

The organization covers emergency services when approved by an authorized representative.

UM 13: Procedures for Pharmaceutical Management 1.00 points

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

Element A: Policies and Procedures 0.10 points

The organization's policies and procedures for pharmaceutical management include:

1. the criteria used to adopt pharmaceutical management procedures
2. a process that uses clinical evidence from appropriate external organizations.

Element B: Pharmaceutical Restrictions/Preferences 0.20 points

The organization maintains a list of pharmaceuticals, including restrictions and preferences, and has policies that address:

1. how to use the pharmaceutical management procedures
2. an explanation of any limits or quotas
3. an explanation of how prescribing practitioners must provide information to support an exceptions request
4. the organization's process for generic substitution, therapeutic interchange and step-therapy protocols.

Element C: Pharmaceutical Patient Safety Issues 0.10 points

The organization's pharmaceutical procedures include:

1. adoption or creation of a system for point of dispensing communications to identify and classify drug-to-drug interactions by severity
2. notification to dispensing providers at the point of dispensing of specific interactions when they meet the organization's severity threshold
3. where possible, identification and notification of members and prescribers affected by FDA-required or voluntary drug withdrawals from the market.

Element D: Review and Update of Procedures 0.20 points

The organization reviews pharmaceutical management procedures at least annually and updates them as new pharmaceutical information becomes available.

Element E: Pharmacist and Practitioner Involvement 0.10 points

The organization involves the following in the development and periodic updates of its pharmaceutical management procedures:

1. pharmacists
2. appropriate practitioners.

Element F: Availability of Procedures 0.10 points

Annually and when it makes changes, the organization provides pharmaceutical management procedures to practitioners.

Element G: Considering Exceptions 0.20 points

The organization has exceptions policies and procedures that describe the process for:

1. making an exception request based on medical necessity
2. obtaining medical necessity information from prescribing practitioners
3. using appropriate pharmacists and practitioners to consider exception requests
4. timely request handling
5. communicating the reason for the denial and an explanation of the appeals process when it does not approve an exception request.

UM 14: Ensuring Appropriate Utilization 2.00 points

The organization facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under- and over-utilization of services.

Element A: Relevant Utilization Data 0.30 points

The organization chooses at least four relevant types of utilization data, including one type related to behavioral health to monitor for each product line.

Element B: Under-/Overutilization Thresholds 0.30 points

The organization sets thresholds for the four data types for each product line, including behavioral health, and annually quantitatively analyzes data against the established thresholds to detect under- and overutilization.

Element C: Qualitative Data Analysis 0.30 points

The organization conducts qualitative analysis to determine the cause and effect of all data not within thresholds.

Element D: Site-Level Monitoring 0.30 points

The organization analyzes data not within thresholds by practice sites.

Element E: Interventions 0.30 points

The organization takes action to address identified problems of under- and overutilization.

Element F: Evaluating Intervention Effectiveness 0.30 points

The organization measures the effectiveness of interventions to address under- and overutilization.

Element G: Affirmative Statement About Incentives 0.20 points

The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions affirming that:

1. UM decision making is based only on appropriateness of care and service and existence of coverage
2. the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care
3. financial incentives for UM decision makers do not encourage decisions that result in underutilization.

UM 15: Triage and Referral for Behavioral Health Care 0.50 points

The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed.

Note: This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and nondelegated.

Element A: Triage and Referral Protocols 0.10 points

The organization's protocols for behavioral health care triage and referral:

1. address all relevant mental health and substance abuse situations
2. define level of urgency
3. define appropriate setting of care
4. have been reviewed or revised within the past two years.

Element B: Clinical Decisions 0.20 points

Licensed practitioners make decisions that require clinical judgment.

Element C: Supervision and Oversight 0.20 points

Supervision and oversight for triage and referral decisions meet the following factors:

1. staff who make clinical decisions are supervised by a licensed master's-level practitioner with five years of post-master's clinical experience
2. a licensed psychiatrist or a licensed doctoral-level clinical psychologist oversees triage and referral decisions.

UM 16: Delegation of UM

If the organization delegates any UM activities, there is evidence of oversight of the delegated activities.

Element A: Written Delegation Agreement

The written delegation document:

1. is mutually agreed upon
2. describes the responsibilities of the organization and the delegated entity
3. describes the delegated activities
4. requires at least semiannual reporting to the organization
5. describes the process by which the organization evaluates the delegated entity's performance
6. describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

Element B: Provisions for PHI

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. a list of the allowed uses of PHI
2. a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3. a stipulation that the delegate will ensure that subdelegates have similar safeguards
4. a stipulation that the delegate will provide individuals with access to their PHI
5. a stipulation that the delegate will inform the organization if inappropriate uses of the information occur
6. a stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

Element C: Approval of UM Program

The organization approves its delegate's UM program annually.

Element D: Predelegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation document was signed.

Element E: Annual Evaluation
For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

Element F: Reporting
For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element A.

Element G: Opportunities for Improvement
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been effect, the organization has identified and followed up on opportunities for improvement, if applicable.

52.101: Appendix B: Standards for Quality Management and Improvement in the NCQA *Standards and Guidelines for the Accreditation of MCOs* effective July 1, 2004

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QI 1: Program Structure 0.50 points

The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.

Element A: Quality Improvement Program Structure 0.30 points

The organization's QI program structure includes the following factors:

1. a written description of the QI program
2. behavioral health care is specifically addressed in the program description
3. patient safety is specifically addressed in the program description
4. the QI program is accountable to the governing body
5. a designated physician has substantial involvement in the QI program
6. a designated behavioral health care practitioner is involved in the behavioral health care aspects of the QI program
7. a QI Committee oversees the QI functions of the organization
8. the specific role, structure and function of the QI Committee and other committees, including meeting frequency, are addressed in the program description
9. an annual work plan
10. a description of resources that the organization devotes to the needs of the QI program.

Element B: QI Program-Time in Place 0.00 points

The QI program has been in effect for at least 12 months.

Note: Mark this element NA for submission.

Element C: Annual Evaliuation 0.20 points

There is an annual written evaluation of the QI program that includes:

1. a description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
2. trending of measures to assess performance in the quality and safety of clinical care and quality of service
3. analysis of the results of QI initiatives, including barrier analysis

QI 2: Program Operations 0.80 points

The organization's quality improvement program is fully operational.

Element A: QI Committee Responsibilities 0.20 points

The organization's QI Committee:

1. recommends policy decisions
2. analyzes and evaluates the results of QI activities

3. ensures practitioner participation in the QI program through planning, design, implementation or review
4. institutes needed actions
5. ensures follow-up, as appropriate.

Element B: QI Committee Minutes 0.30 points
QI Committee meeting minutes reflect all committee decisions and actions, and are signed and dated

Element C: Informing Practictioners and Members 0.10 points
The organization makes information about its QI program available to its practitioners and members, including a description of the QI program and a report on the organization's progress in meeting its goals and provides it upon request

Element D: Safety and Quality Data Collection 0.20 points
The organization has a plan for collecting and providing information on provider and practitioner safety and quality that includes the following:
1. activities to collect information on providers' actions to improve patient safety
2. activities to make performance data publicly available for members and practitioners

QI 3: Health Services Contracting 1.00 points
The organization's contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with the organization's QI program.

Element A: Practictioner Contracts 0.40 points
Contracts with practitioners specifically require that:
1. practitioners cooperate with QI activities
2. the organization has access to practitioner medical records, to the extent permitted by state and federal law
3. practitioners maintain the confidentiality of member information and records.

Element B: Affirmative Statement 0.10 points
Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Element C: Provider Contracts 0.40 points
Contracts with organization providers specifically require that:
1. providers cooperate with QI activities
2. the organization has access to provider medical records, to the extent permitted by state and federal law

3. providers maintain the confidentiality of member information and records.

Element D: Notification of Specialist Termination 0.10 points
Contracts with specialists and specialty group practices require timely notification to organization members affected by the termination of a specialist or the entire specialty group.

QI 4: Availability of Practitioners 1.90 points
The organization ensures that its network has sufficient numbers and types of primary care, behavioral health and specialty care practitioners.

Element A: Cultural Needs and Preferences 0.40 points
The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary

Element B: Ensuring Availability of PCPs 0.50 points
To ensure the availability of primary care practitioners (PCP) within its delivery system, the organization:
1. defines which practitioners serve as PCPs
2. establishes quantifiable and measurable standards for the number of PCPs
3. establishes quantifiable and measurable standards for the geographic distribution of PCPs
4. analyzes performance against the standards annually.

Element C: Ensuring Availability of Specialty Care Practictioners 0.50 points
To ensure the availability of specialty care practitioners (SCP) within its delivery system, the organization:
1. defines which practitioners serve as high-volume SCPs
2. establishes quantifiable and measurable standards for the number of SCPs
3. establishes quantifiable and measurable standards for the geographic distribution of SCPs
4. analyzes performance against the standards annually.

Element D: Ensuring Availability of Behavioral Health Practitioners 0.50 points
To ensure the availability of behavioral health practitioners (BHP) within its delivery system, the organization:
1. defines which practitioners serve as high-volume BHPs
2. establishes quantifiable and measurable standards for the number of BHPs
3. establishes quantifiable and measurable standards for the geographic distribution of BHPs
4. analyzes performance against the standards annually.

QI 5: Accessibility of Services 3.10 points

The organization establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member services.

Element A: Assessmen Against Access Standards 1.90 points

The organization collects and performs an annual analysis of data to measure its performance against standards for access to:

1. regular and routine care appointments
2. urgent care appointments
3. after-hours care
4. telephone service.

Element B: Assessment Against Behavioral Health Access Standards 0.60 points

Using valid methodology, the organization collects and performs an analysis of data to measure its performance against standards for behavioral health access to:

1. care for a non-life-threatening emergency within 6 hours
2. urgent care within 48 hours
3. an appointment for a routine office visit within 10 business days.

Element C: Behavioral Health Telephone Access Standards 0.60 points

Using valid methodology, the organization collects and performs an analysis of data to measure its performance against the following behavioral health telephone access standards:

1. the quarterly average for screening and triage calls shows that telephones are answered by a nonrecorded voice within 30 seconds
2. the quarterly average for screening and triage calls reflects a telephone abandonment rate within 5 percent.

QI 6: Member Satisfaction 3.50 points

The organization implements mechanisms to assure member satisfaction.

Element A: Annual Assessment 2.30 points

To assess member satisfaction, the organization conducts evaluations of member complaints and appeals by:

1. identifying the appropriate population
2. drawing appropriate samples from the affected population, if a sample is used
3. collecting valid data
4. performing the assessment annually.

Element B: Opportunities for Improvement 1.20 points

The organization identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based upon the analysis of:

1. member complaint and appeal data
2. the CAHPS 3.0H survey.

QI 7: Disease Management 3.30 points

The organization actively works to improve the health status of its members with chronic conditions.

Element A: Identifying Chronic Conditions 0.40 points

The organization identifies two chronic conditions that its disease management (DM) programs address.

Element B: Program Content 0.40 points

The content of the organization's programs addresses the following for each condition:

1. condition monitoring
2. patient adherence to the program's treatment plans
3. consideration of other health conditions
4. lifestyle issues as indicated by practice guidelines (e.g., goal-setting techniques, problem solving).

Element C: Identifying Eligible Members 0.40 points

Annually, the organization systematically identifies members who qualify for its programs.

Element D: providing Members Wth Information 0.40 points

The organization provides eligible members with written program information regarding:

1. how to use the services
2. how members become eligible to participate
3. how to opt in or opt out.

Element E: Interventions Based on Stratification 0.40 points

The organization provides interventions to members based on stratification.

Element F: Eligible Member Participation 0.40 points

The organization annually measures member participation rates.

Element G: Informing and Educating Practitioners 0.40 points

The organization provides practitioners with written program information, including:

1. instructions on how to use the DM services
2. how the organization works with a practitioner's patients in the program.

Element H: Measuring Effectiveness 0.50 points

The organization employs and tracks one performance measure for each DM program. Each measurement:

1. addresses a relevant process or outcome
2. produces a quantitative result
3. is population based
4. uses data and methodology that are valid for the process or outcome measured
5. has been analyzed in comparison to a benchmark or goal.

QI 8: Clinical Practice Guidelines 3.20 points

The organization is accountable for adopting and disseminating nonpreventive health clinical practice guidelines relevant to its membership for the provision of nonpreventive health acute and chronic medical services and for preventive and nonpreventive behavioral health services.

Element A: Adopting Relevant Guidelines 0.60 points

The organization has adopted clinical practice guidelines for acute and chronic medical care and for behavioral health care, relevant to its membership.

Element B: Relationship to Disease Management Programs 0.20 points

At least two of the organization's adopted clinical practice guidelines are the clinical basis for DM programs in *QI 7: Disease Management.*

Element C: Clinical Basis for Guidelines 0.60 points

The organization establishes a clinical basis for its guidelines by:

1. using evidence-based clinical practice guidelines
2. using an appropriate body for approval.

Element D: Updating Guidelines 0.60 points

The organization reviews the clinical practice guidelines at least every two years and updates them, as appropriate.

Element E Distribution of Guidelines 0.70 points

The organization distributes the clinical practice guidelines to the appropriate practitioners.

Element F: Performancce Measurement 0.70 points

The organization annually measures performance against at least two important aspects of each of the four clinical practice guidelines, two of which relate to behavioral health.

QI 9: Continuity and Coordination of Medical Care 1.10 points

The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network. The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network

Element A: Identify Opportunities for Improvement 0.30 points

At least annually, the organization identifies and acts on opportunities to improve coordination of medical care by:

1. collecting data
2. conducting quantitative and causal analysis of data to identify improvement opportunities
3. identifying and selecting one opportunity for improvement
4. identifying and selecting a second opportunity for improvement
5. taking action on the first opportunity

6. taking action on the second opportunity.

Element B: Notification of PCP Termination 0.40 points

The organization notifies members affected by the termination of a primary care practitioner at least 30 calendar days prior to the effective termination date and helps them select a new practitioner.

Element C: Continued Access Documentation 0.40 points

The organization allows affected members continued access to their practitioner if the practitioner's contract is discontinued, as follows:

1. continuation of treatment through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition
2. continued access to the practitioner through the postpartum period for members in their second or third trimester of pregnancy.

QI 10: Continuity and Coordination Between Medical and Behavioral Health Care 1.00 points

The organization collaborates with behavioral health specialists to monitor and improve coordination between medical and behavioral health care.

Element A: Data Collection 0.50 points

The organization has collected data at least once in the last two years about the following opportunities for collaboration between medical and behavioral health care:

1. exchange of information
2. appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
3. appropriate uses of psychopharmacological medications
4. management of treatment access and follow-up for members with coexisting medical and behavioral disorders
5. primary or secondary preventive behavioral health program implementation.

Element B: Collaborative Activities 0.50 points

The organization's activities to improve the coordination of behavioral health and general medical care include:

1. collaboration between the organization and behavioral health specialists
2. quantitative and causal analysis of data to identify improvement opportunities
3. identification and selection of at least one opportunity for improvement
4. taking collaborative action to address at least one identified opportunity for improvement.

QI 11: Clinical Quality Improvements 3.30 points

The organization demonstrates improvements in the clinical care of members.

Element A: Clinical Improvements 3.30 points

The organization demonstrates three clinical improvements, one of which is in the behavioral health area and each of which is of either of the following types:

1. significant improvement in one audited HEDIS clinical measure (see *Appendix* 6 for the list of measures)
2. meaningful improvement in a QI clinical activity not addressed by a HEDIS measure in an area relevant to the organization's population.

QI 12: Service Improvements 3.30 points

The organization demonstrates improvements in the service it renders to members

Element A: Service Improvements 3.30 points

The organization demonstrates two service improvements, each of which is of one of the following types:

1. significant improvement in a CAHPS 3.0H composite, rating result or question
2. meaningful improvement in a QI service activity not using CAHPS 3.0H results in an area of service identified as an opportunity and relevant to the organization's membership.

QI 13: Standards for Medical Record Documentation 1.00 points

The organization requires medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

Element A: Medica Record Criteria 0.80 points

The organization has policies and distributes the policies to practice sites that address:

1. confidentiality of medical records
2. medical record documentation standards
3. an organized medical record keeping system and standards for the availability of medical records
4. performance goals to assess the quality of medical record keeping.

Element B: Improving Medical Record Keeping 0.20 points

The organization has implemented a method to improve medical record keeping.

QI 14: Delegation of QI

If the organization delegates any QI activities, there is evidence of oversight of the delegated activity.

Element A: Written Delegation Agreement

There is a written delegation document that:

1. is mutually agreed upon
2. describes the responsibilities of the organization and the delegated entity
3. describes the delegated activities
4. requires at least semiannual reporting to the organization
5. describes the process by which the organization evaluates the delegated entity's performance
6. describes the remedies, including revocation of the delegation, available to the organization

if the delegated entity does not fulfill its obligations

Element B: Provisions for PHI
If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. a list of the allowed uses of PHI
2. a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3. a stipulation that the delegate ensures that subdelegates have similar safeguards
4. a stipulation that the delegate provides individuals with access to their PHI
5. a stipulation that the delegate informs the organization if inappropriate uses of the information occur
6. a stipulation that the delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends.

Element C: Approval of QI Program
The organization approves its delegate's QI program annually.

Element D: Predelegation Evaluation
For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.

Element E: Annual Evaluation
For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

Element F: Reporting
For delegation arrangements in effect for 12 months or longer, the organization evaluates regular reports, as specified in Element A.

Element G: Opportunities for Improvement
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.

52.102: Appendix C: Standards for Credentialing and Recredentialing in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2004

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CR 1: Credentialing Policies 0.50 points

The organization documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action

Element A: Practitioner Credentialing Guidelines 0.30 points

The organization's credentialing policies and procedures specify:

1. types of practitioners to credential and recredential
2. verification sources used
3. criteria for credentialing and recredentialing
4. the process for making credentialing and recredentialing decisions
5. the process for managing credentialing files that meet the organization's established criteria
6. the process to delegate credentialing or recredentialing
7. the process used to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner
8. the process for notifying a practitioner about any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner
9. the process to ensure that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision
10. the medical director or other designated physician's direct responsibility and participation in the credentialing program
11. the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law
12. the process for ensuring that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty.

Element B: Practitioner Rights 0.20 points

The organization's policies and procedures include the following practitioner rights:

1. the right of practitioners to review information submitted to support their credentialing application
2. the right of practitioners to correct erroneous information
3. the right of practitioners to be informed of the status of their credentialing or recredentialing application upon request
4. notification of these rights.

CR 2: Credentialing Committee 0.50 points

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions

Element A: Credentialing Committee 0.20 points

The Credentialing Committee includes representation from a range of participating practitioners.

Element B: Credentialing Committee Decisions 0.30 points

The Credentialing Committee has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet the organization's established criteria, and to offer advice, which the organization considers.

CR 3: Initial Credentialing Verification 1.20 points

The organization verifies credentialing information through primary sources, unless otherwise indicated

Element A: Licensure Verification 0.60 points

The organization verifies that a current, valid license to practice is present and within the prescribed time limits.

Element B: Initial Primary Source Verification 0.60 points

The organization verifies that the following factors are present and within the prescribed time limits:

1. a valid DEA or CDS certificate, if applicable
2. education and training including board certification, if the practitioner states on the application that he or she is board certified
3. work history
4. a history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

CR 4: Application and Attestation 0.40 points

A practitioner completes an application for membership that includes a current and signed attestation regarding his or her health status and any history of loss or limitations of licensure or privileges

Element A: Contents of the Application 0.40 points

The application includes a current and signed attestation and addresses:

1. reasons for any inability to perform the essential functions of the position, with or without accommodation
2. lack of present illegal drug use
3. history of loss of license and felony convictions
4. history of loss or limitation of privileges or disciplinary activity
5. current malpractice insurance coverage
6. the correctness and completeness of the application.

CR 5: Initial Sanction Information 1.00 points

There is documentation that before making a credentialing decision the organization receives information on practitioner sanctions

Element A: Sanction Information 1.00 points

In an NCQA review of credentialing files, two factors are present and within the 180-calendar-day time limit:

1. state sanctions, restrictions on licensure and/or limitations on scope of practice
2. Medicare and Medicaid sanctions.

CR 6: Initial Credentialing Site Visits 1.30 points

The organization has a process to ensure that the offices of all primary care practitioners, obstetricians/gynecologists and high-volume behavioral health care practitioners meet its office-site standards

Element A: Performance Standards and Thresholds 0.40 points

The organization:

1. sets standards for office site criteria and medical/ treatment record-keeping practice
2. establishes a threshold for acceptable performance.

Element B: Site Visits and Medical Record-Keeping 0.40 points

For PCPs, OB/GYNs and high-volume behavioral health specialists, the organization conducts:

1. an initial site visit
2. an initial evaluation of medical/treatment record-keeping practices at each site.

Element C: Follow-Up for Initial Site Visits 0.50 points

The organization implements ongoing monitoring and takes appropriate interventions by:

1. instituting actions for improving sites that do not meet the thresholds
2. evaluating the effectiveness of the actions at least every six months, until deficient sites meet the thresholds
3. monitoring all sites for any deficiencies subsequent to the initial site visit at least every six months
4. documenting follow-up visits for those sites that had subsequent deficiencies, if applicable.

CR 7: Recredentialing Verification 1.10 points

The organization formally recredentials its practitioners at least every 36 months through information verified from primary sources, unless other wise indicated

Element A: Licensure Verification 0.30 points

The organization verifies that a current, valid license to practice is present and within the prescribed time limits.

Element B: Recredentialing Verification 0.30 points

The organization verifies the following factors within the prescribed time limits:

1. a valid DEA or CDS certificate, as applicable
2. board certification, as specified
3. history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

Element C: Application Correctness/Completeness 0.30 points

The application for membership includes a current and signed attestation with the following factors:

1. reasons for any inability to perform the essential functions of the position, with or without accommodation
2. lack of present illegal drug use
3. history of loss or limitation of privileges or disciplinary activity
4. current malpractice insurance coverage
5. correctness and completeness of the application.

Element D: Recredentialing Cycle Length 0.20 points
The length of the recredentialing cycle is within the required 36-month time frame.

CR 8: Recredentialing Sanction Information 1.00 points
There is documentation that before making a recredentialing decision, the organization receives information on practitioner sanctions

Element A: Sanction Information 0.80 points
In an NCQA review of recredentialing files, two elements are present and within the 180-calendar-day time limit:

1. state sanctions, restrictions on licensure and/or limitations on scope of practice
2. Medicare and Medicaid sanctions.

Element B: Recredentialing Cycle Length 0.20 points
In a review of a sample of the organization's recredentialing files, the length of the recredentialing cycle is within the 3-year (36-month) time frame.

CR 9: Ongoing Monitoring of Sanctions, Complaints and Quality Issues 2.00 points
The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality

Element A: Ongoing Monitoring and Interventions 2.00 points
The organization implements ongoing monitoring and takes appropriate interventions by:

1. collecting and reviewing Medicare and Medicaid sanctions
2. collecting and reviewing sanctions or limitations on licensure
3. collecting and reviewing complaints
4. implementing appropriate interventions when it identifies instances of poor quality, when appropriate.

CR 10: Notification to Authorities and Practitioner Appeal Rights 0.40 points

An organization that has taken actions against a practitioner for quality reasons offers the practitioner a formal appeal process and reports the action to the appropriate authorities

Element A: Written Policy and Procedures 0.10 points

The organization has policies and procedures for:

1. the range of actions available to the organization
2. reporting to authorities
3. a well-defined appeal process
4. making the appeal process known to practitioners.

Element B: Reporting to Appropriate Authorities 0.20 points

There is documentation that the organization reports practitioner suspension or termination to the appropriate authorities.

Element C: Practitioner Appeal Process 0.10 points

The organization has an appeal process for instances in which it chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service. The organization informs practitioners of the appeal process.

CR 11: Assessment of Organizational Providers 0.60 points

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract

Element A: Review and Approval of Provider 0.20 points

The organization's policy for credentialing of health care delivery providers specifies that it:

1. confirms that the provider is in good standing with state and federal regulatory bodies
2. confirms that the provider has been reviewed and approved by an accrediting body
3. conducts an onsite quality assessment, if there is no accreditation status
4. confirms at least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable is reviewed and approved by an accrediting body at least every three years.

Element B: Medical Providers 0.10 points

The organization includes at least the following medical providers:

1. hospitals
2. home health agencies
3. skilled nursing facilities
4. freestanding surgical centers.

Element C: Mental Health and Substance Abuse 0.10 points

The organization includes behavioral health facilities providing mental health or substance abuse services in the following settings:

1. inpatient
2. residential
3. ambulatory.

Element D: Assessing Medical Care Providers 0.10 points

The organization has documentation of assessment of contracted medical health care delivery providers.

Element E: Assessing Behavioral Health Providers 0.10 points

The organization has documentation of assessment of contracted behavioral health care delivery providers.

CR 12: Delegation of CR

If the organization delegates any credentialing activities, there is evidence of oversight of the delegated activity

Element A: Written Delegation Agreement

The written delegation document:

1. is mutually agreed upon
2. describes the responsibilities of the organization and the delegated entity
3. describes the delegated activities
4. requires at least semiannual reporting to the organization
5. describes the process by which the organization evaluates the delegated entity's performance
6. describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

Element B: Provisions for PHI

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. a list of the allowed uses of PHI
2. a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3. a stipulation that the delegate will ensure that subdelegates have similar safeguards
4. a stipulation that the delegate will provide individuals with access to their PHI
5. a stipulation that the delegate will inform the organization if inappropriate uses of the information occur
6. a stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

Element C: Approval of CR Program

The organization approves its delegate's CR program annually.

Element D: Predelegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation document was signed.

Element E: Annual Evaluation
For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

Element F: Reporting
For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element A.

Element G: Opportunities for Improvement
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been effect, the organization has identified and followed up on opportunities for improvement, if applicable.

52.110: Appendix D: Standards for Utilization Management in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans effective July 1, 2004

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UM 1: Utilization Management Structure 0.40 points
The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.

Element A: Written Program Description 0.10 points
The organization's UM program description includes the following factors:

1. program structure
2. behavioral health care aspects of the program
3. involvement of a designated senior physician in UM program implementation
4. involvement of a designated behavioral health care practitioner in the implementation of the behavioral health care aspects of the UM program
5. scope of the program
6. processes and information sources used to make determinations of benefit coverage and medical necessity
7. appeal procedures
8. role of the QI program
9. accountability.

Element B: Physician Involvement 0.10 points
A senior physician is actively involved in implementing the UM program.

Element C: Behavioral Health Involvement 0.10 points
A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the UM program.

Element D: Annual Evaluation 0.10 points
The organization annually evaluates and updates the UM program, as necessary.

UM 2: Clinical Criteria for UM Decisions 2.80 points
To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.

Element A: UM Criteria 1.20 points
The organization:

1. has written UM decision-making criteria that are objective and based on medical evidence
2. has written policies for applying the criteria based on individual needs
3. has written policies for applying the criteria based on an assessment of the local delivery system
4. involves appropriate practitioners in developing, adopting and reviewing criteria

5. has a process for annually reviewing and updating UM criteria and the procedures for applying them.

Element B: Availability of Criteria 0.80 points

The organization:

1. states in writing how practitioners can obtain UM criteria
2. makes the criteria available to its practitioners upon request.

Element C: Consistency in Applying Criteria 0.80 points

The organization annually evaluates the consistency with which health care professionals involved in UM apply criteria in decision making and acts on opportunities for improvement, if applicable.

UM 3: Communication Services 0.30 points

The organization provides access to staff for enrollees and practitioners seeking information about the UM process and the authorization of care.

Element A: Access to Staff 0.30 points

The organization provides the following communication services for practitioners and enrollees:

1. availability of staff at least eight hours a day during normal business days for inbound calls regarding UM issues
2. ability of staff to receive inbound communication regarding UM issues after normal business hours
3. outbound communication from staff regarding inquiries about UM during normal business hours, unless otherwise agreed upon
4. staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues
5. a toll-free number or staff that accept collect calls regarding UM issues
6. access to staff for callers with questions about the UM process.

UM 4: Appropriate Professionals 2.10 points

Qualified licensed health professionals assess the clinical information used to support UM decisions.

Element A: Licensed Health Professionals 0.70 points

The organization has written procedures:

1. requiring appropriately licensed professionals to supervise all medical necessity decisions
2. specifying the type of personnel responsible for each level of UM decision making.

Element B: Use of Practitioners for UM Decisions 0.40 points

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity that requires:

1. education, training or professional experience in medical or clinical practice
2. a current license to practice without restriction.

Element C: Practitioner Review of Denials 0.70 points

The organization ensures that a physician, behavioral health practitioner, dentist or pharmacist, as appropriate, reviews any denial based on medical necessity.

Element D: Use of Board-Certified Consultants 0.30 points

The organization has written procedures for using board-certified consultants to assist in making medical necessity determinations.

UM 5: Timeliness of UM Decisions 3.10 points

The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

Element A: Timeliness of UM Decision Making 1.50 points

The organization adheres to the following standards for timeliness of UM decision making:

1. for nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request
2. for urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request
3. for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request
4. for postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Element B: Notification of Behavioral Health Decisions 1.60 points

The organization adheres to the following standards for notification of UM decision making:

1. for nonurgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and enrollees within 15 calendar days of the request
2. for urgent preservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and enrollees within 72 hours of the request
3. for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and enrollees within 24 hours of the request
4. for postservice denial decisions, the organization gives electronic or written notification of the decision to practitioners and enrollees within 30 calendar days of the request.

UM 6: Clinical Information 1.70 points

When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating physician.

Element A: Information for UM Decision Making 0.50 points

The organization has a written description that identifies the information that is needed to support UM decision making in place for at least 12 months.

Element B: Procedures for Onsite Facility Reviews 0.20 points

If the organization provides onsite review services at facilities, it has a documented

process that includes:

1. guidelines for identification of organization staff at the facility, in accordance with facility procedures
2. a process for scheduling the onsite review in advance, unless otherwise agreed upon
3. a process for ensuring that staff follows facility rules.

Element C: Relevant Clinical Information 0.70 points

There is documentation that relevant clinical information is gathered consistently to support UM decision making.

Element D: Transition to Other Care 0.30 points

The organization assists with an enrollee's transition to other care, if necessary, when benefits end.

UM 7: Denial Notices 2.30 points

The organization clearly documents and communicates the reasons for each denial.

Element A: Notification of Reviewer Availability 0.40 points

The organization notifies practitioners of:

1. its policy for making a reviewer available to discuss any UM denial decision
2. how to contact the reviewer.

Element B: Discussing a Denial With a Reviewer 0.70 points

The organization provides practitioners with the opportunity to discuss any UM denial decision with a physician or other appropriate practitioner.

Element C: Reason for Denial 0.60 points

The organization provides written notification of the denial that contains the following:

1. the specific reasons for the denial, in easily understandable language
2. a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
3. notification that the enrollee can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

Element D: Notice of Appeals Rights/Process 0.60 points

The organization provides written notification that contains the following:

1. description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal
2. explanation of the appeal process, including the right to enrollee representation and time frames for deciding appeals
3. if a denial is an urgent preservice or urgent concurrent denial, a description of the expedited appeal process.

UM 8: Policies for Appeals 1.50 points

The organization has written policies and procedures for thorough, appropriate and timely resolution of enrollee appeals.

Element A: Policies and Procedures 0.20 points

The organization has written policies and procedures in place for registering and responding to:

1. preservice appeals
2. postservice appeals
3. expedited appeals
4. external appeals.

Element B: Preservice Appeals 0.30 points

The organization's written policies and procedures for registering and responding to written preservice appeals include the following factors:

1. allowance of at least 180 days after notification of the denial for the enrollee to file an appeal
2. documentation of the substance of a preservice appeal and any actions taken
3. full investigation of the substance of the appeal, including any aspects of clinical care involved
4. the opportunity for the enrollee to submit written comments, documents or other information relating to the appeal
5. the appointment of a new person to review a preservice appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination
6. the appointment of at least one person to review a preservice appeal who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment (this applies to medical necessity appeals only)
7. the decision of the preservice appeal and notification to the enrollee within 30 calendar days of receipt of the request
8. notification to the enrollee about further appeal rights
9. procedures for providing to the enrollee upon request, access to and copies of all documents relevant to the enrollee's appeal
10. procedures for allowing an authorized representative to act on behalf of the enrollee
11. procedures for expedited preservice appeals, which include the initiation, decision and notification process.

Element C: Postservice Appeals 0.30 points

The organization's written policies and procedures for registering and responding to written postservice appeals include the following factors:

1. allowance of at least 180 days after notification of the denial for the enrollee to file an appeal
2. documentation of the substance of postservice appeals and actions taken
3. full investigation of the substance of the appeal, including any aspects of clinical care involved

4. the opportunity for the enrollee to submit written comments, documents or other information relating to the appeal
5. the appointment of a new person to review postservice appeals who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination
6. the appointment of at least one person to review postservice appeals who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment (this applies to medical necessity appeals only)
7. the decision of the postservice appeal and notification to the enrollee within 60 calendar days of receipt of the request
8. notification to the enrollee about further appeal rights
9. procedures for providing to the enrollee, upon request, access to and copies of all documents relevant to the enrollee's appeal
10. procedures for allowing an authorized representative to act on behalf of the enrollee.

Element D: External Reviews in States Without Laws 0.20 points

The organization's written policies and procedures for providing independent, external review of final determinations includes:

1. eligibility criteria stating that the organization offers enrollees the right to an independent, third-party, binding review for all medical necessity denials
2. a general communication to enrollees announcing the availability of the right to independent review, at least annually
3. a specific written or electronic notification to enrollees of the independent appeal rights and processes, including contact information for the independent review organization (IRO) for eligible internal appeals that are denied
4. a thorough review by the IRO in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence and makes a decision that is not bound by the decisions or conclusions of the internal appeal
5. the IRO has no material professional, familial or financial conflicts of interest with the organization
6. the organization must not attempt to interfere with the IRO's proceedings or appeal decision
7. the enrollee is not required to bear costs of the IRO, including any filing fees
8. the enrollee or the enrollee's legal guardian may designate, in writing, a representative to act on the enrollee's behalf
9. notification to enrollees of the IRO decision, including time and procedure for claim payment or approval of service, in the event the IRO overturns the organization's decision
10. the organization implements the IRO's decision within the time frame specified by the IRO
11. the organization maintains or obtains from the IRO data on each appeal case and uses this information in evaluating its medical necessity decision-making process.

Element E: External Reviews in States With Laws 0.30 points

The organization's written policies and procedures for providing independent, external review of final determinations include the following required factors:

1. general communication to enrollees announcing the availability of the right to independent review, at least annually
2. for eligible internal appeals where the determination is adverse to the enrollee, specific written or electronic notification to enrollees of the independent appeal rights and processes, including contact information for the IRO.

Element F: Time Elements Are in Place 0.20 points

The organization's policies and procedures for handling appeals are in place for at least six months.

UM 9: Appropriate Handling of Appeals 5.40 points

The organization adjudicates member appeals in a thorough, appropriate and timely manner.

Element A: Preservice and Postservice Appeals 0.80 points

An NCQA review of the organization's appeal files indicates that there is:

1. documentation of the substance of appeals
2. investigation of appeals.

Element B: Timeliness of the Appeal Process 0.80 points

Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frame:

1. the organization resolves preservice appeals within 30 calendar days of receipt of the request
2. the organization resolves postservice appeals within 60 calendar days of receipt of the request
3. the organization resolves expedited appeals within 72 hours of the request.

Element C: Appeal Reviewers 0.80 points

The organization provides for nonsubordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate.

Element D: Notification of Appeal Decision/Rights 0.80 points

An NCQA review of the organization's internal appeal files indicates notification to enrollee of:

1. the specific reasons for the appeal decision, in easily understandable language
2. a reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
3. notification that the enrollee, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
4. notification that the enrollee is entitled to receive, upon request, reasonable access to

and copies of all documents relevant to the enrollee's appeal
5. a list of titles and qualifications of individuals participating in the appeal review
6. a description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.

Element E: Appropriate Handling of Appeals 0.80 points

A review of the organization's internal appeal files indicates appropriate handling of appeals.

Element F: Final Internal and External Appeal Files 0.70 points

In an NCQA review of denials overturned by the IRO or of the organization's final internal denials the files included:

1. enrollee notification of independent appeal rights
2. enrollee notification about obtaining more information regarding independent appeal rights
3. a statement that enrollees are not required to bear costs of the independent review organization, including any filing fees.

Element G: Appeals Overturned by the IRO 0.70 points

In a review of the organization's files of appeals overturned by the IRO, there was evidence that the organization implemented the IRO's decision in all cases reviewed.

UM 10: Evaluation of New Technology 2.30 points

The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals and devices.

Element A: Description of the Evaluation Process 1.40 points

The organization's written evaluation process includes the following factors:

1. the process and decision variables the organization uses to make determinations
2. a review of information from appropriate government regulatory bodies
3. a review of information from published scientific evidence
4. a process for seeking input from relevant specialists and professionals who have expertise in the technology.

Element B: Evaluated New Technology Implementation 0.90 points

The organization implements a decision on coverage from its assessment of new technologies and new applications of existing technologies or from review of special cases.

UM 11: Satisfaction With the UM Process 3.80 points

The organization evaluates member and practitioner satisfaction with the utilization management process.

Element A: Assessing Satisfaction With the UM Process 3.80 points

The organization's evaluation of satisfaction with the UM process includes the following factors:

1. the use of information from enrollees regarding their satisfaction with the UM process.
2. the use of information from practitioners regarding their satisfaction with the UM process.
3. gathering information about satisfaction with the UM process at least annually.
4. taking strong action to address opportunities for improvement identified from information gathered about satisfaction with the UM process.

UM 12: Emergency Services 2.30 points

The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.

Element A: Policies and Procedures 0.30 points

The organization's emergency services policies and procedures require:

1. coverage of emergency services to screen and stabilize the enrollee without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
2. coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency services.

Element B: Review of Presenting Symptoms 1.00 points

A physician reviews presenting symptoms as well as the discharge diagnosis for emergency services.

Element C: Organization's Authorized Representative 1.00 points

The organization covers emergency services when approved by an authorized representative.

UM 13: Procedures for Pharmaceutical Management 1.50 points

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

Element A: Policies and Procedures 0.20 points

The organization's policies and procedures for pharmaceutical management include:

1. the criteria used to adopt pharmaceutical management procedures
2. a process that uses clinical evidence from appropriate external organizations.

Element B: Pharmaceutical Restrictions/Preferences 0.20 points

The organization maintains a list of pharmaceuticals, including restrictions and preferences, and has policies that address:

1. how to use the pharmaceutical management procedures
2. an explanation of any limits or quotas
3. an explanation of how prescribing practitioners must provide information to support an exceptions request
4. the organization's process for generic substitution, therapeutic interchange and

step-therapy protocols.

Element C: Pharmaceutical Patient Safety Issues 0.10 points
The organization's pharmaceutical procedures include:
1. adoption or creation of a system for point of dispensing communications to identify and classify drug-to-drug interactions by severity
2. notification to dispensing providers at the point of dispensing of specific interactions when they meet the organization's severity threshold
3. where possible, identification and notification of enrollees and prescribers affected by FDA-required or voluntary drug withdrawals from the market.

Element D: Review and Update of Procedures 0.30 points
The organization reviews pharmaceutical management procedures at least annually and updates them as new pharmaceutical information becomes available.

Element E: Pharmacist and Practitioner Involvement 0.20 points
The organization involves the following in the development and periodic updates of its pharmaceutical management procedures:
1. pharmacists
2. appropriate practitioners.

Element F: Availability of Procedures 0.20 points
Annually and when it makes changes, the organization provides pharmaceutical management procedures to practitioners.

Element G: Considering Exceptions 0.30 points
The organization has exceptions policies and procedures that describe the process for:
1. making an exception request based on medical necessity
2. obtaining medical necessity information from prescribing practitioners
3. using appropriate pharmacists and practitioners to consider exception requests
4. timely request handling
5. communicating the reason for the denial and an explanation of the appeals process when it does not approve an exception request.

UM 14: Ensuring Appropriate Utilization 2.00 points
This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

UM 15: Triage and Referral for Behavioral Health Care 0.50 points
The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed.
Note: This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and nondelegated.

Element A: Triage and Referral Protocols 0.20 points

The organization's protocols for behavioral health care triage and referral:

1. address all relevant mental health and substance abuse situations.
2. define level of urgency.
3. define appropriate setting of care.
4. have been reviewed or revised within the past two years.

Element B: Clinical Decisions 0.20 points

Licensed practitioners make decisions that require clinical judgment.

Element C: Supervision and Oversight 0.10 points

Supervision and oversight for triage and referral decisions meet the following factors:

1. staff who make clinical decisions are supervised by a licensed master's-level practitioner with five years of post-master's clinical experience.
2. a licensed psychiatrist or a licensed doctoral-level clinical psychologist oversees triage and referral decisions.

UM 16: Delegation of UM

If the organization delegates any UM activities, there is evidence of oversight of the delegated activities.

Element A: Written Delegation Agreement

The written delegation document:

1. is mutually agreed upon.
2. describes the responsibilities of the organization and the delegated entity.
3. describes the delegated activities.
4. requires at least semiannual reporting to the organization.
5. describes the process by which the organization evaluates the delegated entity's performance.
6. describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

Element B: Provisions for PHI

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. a list of the allowed uses of PHI.
2. a description of delegate safeguards to protect the information from inappropriate use or further disclosure.
3. a stipulation that the delegate will ensure that subdelegates have similar safeguards
4. a stipulation that the delegate will provide individuals with access to their PHI.
5. a stipulation that the delegate will inform the organization if inappropriate uses of the information occur.
6. a stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

Element C: Approval of UM Program

The organization approves its delegate's UM program annually.

Element D: Predelegation Evaluation
For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation document was signed.

Element E: Annual Evaluation
For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

Element F: Reporting
For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element A.

Element G: Opportunities for Improvement
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been effect, the organization has identified and followed up on opportunities for improvement, if applicable.

52.111: Appendix E: *Standards for Quality Management and Improvement in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans* effective July 1, 2004

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QI 1: Program Structure 1.00 points

The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.

Element A: Quality Improvement Program Structure 0.50 points

The organization's QI program structure includes the following factors:

1. a written description of the QI program.
2. the content of the QI program is addressed in the program description; specific aspects include overall goals and objectives, program subjects and quality indicators.
3. behavioral health care is specifically addressed in the program description.
4. patient safety is specifically addressed in the program description.
5. the QI program is accountable to the governing body.
6. a designated physician has substantial involvement in the QI program.
7. a designated behavioral health care practitioner is involved in the behavioral health care aspects of the QI program.
8. a QI Committee oversees the QI functions of the organization.
9. a description of resources that the organization devotes to the needs of the QI program.

Element B: Annual Evaluation 0.50 points

At least annually, the organization completes a written evaluation of its QI program that includes an analysis of service-related indicators against goals and objectives and patient safety and reports its findings to management.

QI 2: Program Operations 0.70 points

The organization’s quality improvement program is fully operational.

Element A: QI Committee Responsibilities 0.20 points

The organization's QI Committee:

1. recommends policy decisions.
2. analyzes and evaluates the results of QI activities.
3. institutes needed actions.
4. ensures follow-up, as appropriate.

Element B: QI Committee Minutes 0.20 points

QI Committee meeting minutes reflect all committee decisions and actions, and are signed and dated.

Element C: Informing Practitioners and Enrollees 0.10 points

The organization makes information about its QI program available to its practitioners and enrollees, including a description of the QI program and a report on the organization's progress in meeting its goals, and provides it upon request.

Element D: Safety and Quality Data Collection 0.20 points

The organization has a plan for collecting and providing information on provider and practitioner safety and quality that includes:

1. activities to collect information on providers' actions to improve patient safety.
2. activities to make performance data publicly available for enrollees and practitioners.

QI 3: Health Services Contracting 1.10 points

The organization's contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with the organization's QI program.

Element A: Practictioner Contracts 0.40 points

Contracts with practitioners specifically require that:

1. the organization has access to practitioner medical records, to the extent permitted by state and federal law.
2. practitioners maintain the confidentiality of enrollee information and records.

Element B: Affirmative Statement 0.10 points

Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Element C: Notification of Specialist Termination 0.20 points

Contracts with practitioners and practice sites require timely notification to organization enrollees affected by the termination of a practitioner or the entire practice site.

Element D: Provider Contracts 0.40 points

Contracts with organization providers specifically require that:

1. the organization has access to provider medical records, to the extent permitted by state and federal law.
2. providers maintain the confidentiality of enrollee information and records.

QI 4: Availability of Practitioners 3.00 points

The organization ensures that its network has sufficient numbers and types of primary care, behavioral health and specialty care practitioners.

Element A: Cultural Needs and Preferences 0.40 points

The organization assesses the cultural, ethnic, racial and linguistic needs of its enrollees and adjusts the availability of practitioners within its network, if necessary.

Element B: Number of Distribution of Practitioners 1.30 points

The organization has quantifiable and measurable standards for the number and geographic distribution of:

1. general and internal medicine.
2. family practice.
3. Pediatrics.
4. obstetrics/gynecology.
5. high-volume behavioral health care (identified by the organization).
6. a high-volume specialty (identified by the organization).
7. a second high volume specialty (identified by the organization).

Element C: Assesssment of Performance 1.30 points

The organization annually assesses its performance against the standards established for the availability of practitioners.

QI 5: Accessibility of Services 5.00 points

The organization establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member services.

Element A: Assessment Against Access Standards 3.20 points

The organization collects and performs an annual analysis of data to measure its performance against standards for access to:

1. routine care appointments.
2. urgent care appointments.
3. after-hours care.
4. telephone service.

Element B: Assessment Against Behavioral Health Access Standards 0.90 points

Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against standards for behavioral health access to:

1. care for a non-life-threatening emergency within 6 hours.
2. urgent care within 48 hours.
3. an appointment for a routine office visit within 10 business days.

Element C: Behavioral Health Telephone Access Standards 0.90 points

Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against the following behavioral health telephone access standards:

1. the quarterly average for screening and triage calls shows that telephones are answered by a nonrecorded voice within 30 seconds.
2. the quarterly average for screening and triage calls reflects a telephone abandonment rate

within 5 percent.

QI 6: Enrollee Satisfaction 5.50 points

The organization implements mechanisms to assure member satisfaction.

Element A: Annual Assessment 2.00 points

To assess enrollee satisfaction, the organization conducts annual evaluations of enrollee complaints and appeals by:

1. identifying the appropriate population.
2. drawing appropriate samples from the affected population, if a sample is used.
3. collecting valid data.
4. performing the assessment annually.

Element B: Other Systematic Assessments 1.90 points

The organization assesses enrollee satisfaction using a second systematic methodology by:

1. identifying the appropriate population.
2. drawing appropriate samples from the affected population, if a sample is used.
3. collecting valid data.
4. performing the assessment annually.

Element C: Identify Opportunities for Improvement 1.60 points

The organization analyzes findings from the following types of satisfaction data:

1. enrollee complaints and appeals data.
2. the CAHPS 3.0H survey or other systematic assessments.

QI 7: Disease Management

This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

QI 8: Clinical Practice Guidelines

This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

QI 9: Continuity and Coordination of Medical Care 3.40 points

The organization ensures continuity and coordination of care when contracts between the organization and network practitioners or practice sites are discontinued.

Element A: Continued Access Policies 3.40 points

The organization has policies, procedures and evidence of continued access when a practitioner's contract is discontinued. Policies and procedures allow the following:

1. continuation of treatment through the lesser of the current period of active treatment, or up to 90 calendar days for enrollees undergoing active treatment for a chronic or acute medical condition.
2. continued access to the practitioner through the postpartum period for enrollees in their second or third trimester of pregnancy.

QI 10: Continuity and Coordination Between Medical and Behavioral Health Care 1.00 points

This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

QI 11: Clinical Quality Improvements

This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

QI 12: Effectiveness of the QI Program 5.30 points

The organization demonstrates improvements in the service it renders to members.

Element A: Analysis of Quality Indicators 1.60 points

The organization reviews analyses of quality indicators and activities against goals at least annually.

Element B: Opportunities for Improvements 1.80 points

The organization designs and undertakes action to attain improvement goals in at least two areas annually.

Element C: Meaningful Improvement 1.90 points

The organization demonstrates meaningful improvements in the quality of care and service it renders to enrollees.

QI 13: Standards for Medical Record Documentation 1.00 points

This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

QI 14: Delegation of QI

If the organization delegates any QI activities, there is evidence of oversight of the delegated activity.

Element A: Written Delegation Agreement

The written delegation document:

1. is mutually agreed upon.
2. describes the responsibilities of the organization and the delegated entity.
3. describes the delegated activities.
4. requires at least semiannual reporting to the organization.
5. describes the process by which the organization evaluates the delegated entity's performance.

6. describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

Element B: Provisions for PHI

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. a list of the allowed uses of PHI.
2. a description of delegate safeguards to protect the information from inappropriate use or further disclosure.
3. a stipulation that the delegate will ensure that subdelegates have similar safeguards.
4. a stipulation that the delegate will provide individuals with access to their PHI.
5. a stipulation that the delegate will inform the organization if inappropriate uses of the information occur.
6. a stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

Element C: Approval of QI Program

The organization approves its delegate's QI program annually.

Element D: Predelegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation document was signed.

Element E: Annual Evaluation

For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

Element F: Reporting

For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element A.

Element G: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been effect, the organization has identified and followed up on opportunities for improvement, if applicable.

52.112: Appendix F: *Standards for Credentialing and Recredentialing in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans* effective July 1, 2004

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CR 1: Credentialing Policies 0.30 points

The organization documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action

Element A: Practitioner Credentialing Guidelines 0.20 points

The organization's credentialing policies and procedures specify:

1. types of practitioners to credential and recredential
2. verification sources used.
3. criteria for credentialing and recredentialing decisions.
4. the process for making credentialing and recredentialing decisions.
5. the process for managing credentialing files that meet the organization's established criteria.
6. the process to delegate credentialing and recredentialing.
7. the process used to ensure that credentialing and recredentialing are conducted in a nondiscriminatory manner.
8. the process for notifying a practitioner about any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner.
9. the process to ensure that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision.
10. the medical director or other designated physician's direct responsibility and participation in the credentialing program .
11. the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.
12. the process for ensuring that listings in practitioner directories and other materials for enrollees are consistent with credentialing data, including education, training, certification and specialty.

Element B: Practitioner Rights 0.10 points

The organization's policies and procedures include the following practitioner rights:

1. the right of practitioners to review information submitted to support their credentialing application.
2. the right of practitioners to correct erroneous information.
3. the right of practitioners to be informed of the status of their credentialing or recredentialing application upon request.
4. notification of these rights.

CR 2: Credentialing Committee 0.50 points

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions

Element A: Credentialing Committee 0.20 points

The Credentialing Committee includes representation from a range of participating practitioners.

Element B: Credentialing Committee Decisions 0.30 points

The Credentialing Committee has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet the organization's established criteria, and to offer advice, which the organization considers.

CR 3: Initial Credentialing Verification 3.20 points

The organization verifies credentialing information through primary sources, unless otherwise indicated

Element A: Licensure Verification 1.60 points

The organization verifies that a current valid license to practice is present and within the prescribed time limits.

Element B: Initial Primary Source Verification 1.60 points

The organization verifies that the following factors are present and within the prescribed time limits:

1. a valid DEA or CDS certificate, if applicable .
2. education and training including board certification, if the practitioner states on the application that he or she is board certified.
3. work history.
4. a history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

CR 4: Application and Attestation 1.10 points

A practitioner completes an application for membership that includes a current and signed attestation regarding his or her health status and any history of loss or limitations of licensure or privileges

Element A: Contents of the Application 1.10 points

The application includes a current and signed attestation and addresses:

1. reasons for any inability to perform the essential functions of the position, with or without accommodation .
2. lack of present illegal drug use.
3. history of loss of license and felony convictions.
4. history of loss or limitation of privileges or disciplinary activity.
5. current malpractice insurance coverage.

6. the correctness and completeness of the application.

CR 5: Initial Sanction Information 2.90 points

There is documentation that before making a credentialing decision the organization receives information on practitioner sanctions

Element A: Sanction Information 2.90 points

The organization verifies the following sanction information within 180 calendar days of the Credentialing Committee's decision:

1. state sanctions, restrictions on licensure or limitations on scope of practice.
2. Medicare and Medicaid sanctions.

CR 6: Initial Credentialing Site Visits 1.30 points

This standard is not included in PPO plan accreditation. The number is reserved to maintain consistency with other NCQA Accreditation programs.

CR 7: Recredentialing Verification 2.90 points

The organization formally recredentials its practitioners at least every 36 months through information verified from primary sources, unless other wise indicated.

Element A: Licensure Verification 0.60 points

The organization verifies that a current, valid license to practice is present and within the prescribed time limits.

Element B: Recredentialing Verification 0.60 points

The organization verifies the following factors within the prescribed time limits:

1. a valid DEA or CDS certificate, as applicable
2. board certification, as specified
3. history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

Element C: Application Correctness/Completeness 0.50 points

The application for membership includes a current and signed attestation with the following factors:

1. reasons for any inability to perform the essential functions of the position, with or without accommodation .
2. lack of present illegal drug use.
3. history of loss or limitation of privileges or disciplinary activity.
4. current malpractice insurance coverage.
5. correctness and completeness of the application.

Element D: Recredentialing Cycle Length 0.10 points

The length of the recredentialing cycle is within the required 36-month time frame.

Element E: Evidence of Recredentialing 0.50 points

The organization recredentialed at least 30 percent of its licensed independent practitioners by the time of its initial accreditation review.

Element F: Attestation to Ongoing Recredentialling 0.60 points

The organization annually submits an attestation indicating that it has met the required recredentialing schedule.

CR 8: Recredentialing Sanction Information 2.90 points

There is documentation that before making a recredentialing decision, the organization receives information on practitioner sanctions.

Element A: Sanction Information 0.80 points

In an NCQA review of recredentialing files, two elements are present and within the 180-calendar-day time limit:

1. state sanctions, restrictions on licensure and/or limitations on scope of practice.
2. Medicare and Medicaid sanctions.

Element B: Recredentialing Cycle Length 2.10 points

In a review of a sample of the organization's recredentialing files, the length of the recredentialing cycle is within the 3-year (36-month) time frame.

CR 9: Ongoing Monitoring of Sanctions, Complaints and Quality Issues 3.50 points

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

Element A: Ongoing Monitoring and Interventions 3.50 points

The organization implements ongoing monitoring and takes appropriate interventions by:

1. collecting and reviewing Medicare and Medicaid sanctions.
2. collecting and reviewing sanctions or limitations on licensure.
3. collecting and reviewing complaints.
4. implementing appropriate interventions when it identifies instances of poor quality, when appropriate.

CR 10: Notification to Authorities and Practitioner Appeal Rights 1.10 points

An organization that has taken actions against a practitioner for quality reasons offers the practitioner a formal appeal process and reports the action to the appropriate authorities

Element A: Written Policy and Procedures 0.40 points

The organization has policies and procedures for:

1. the range of actions available to the organization

2. reporting to authorities
3. a well-defined appeal process
4. making the appeal process known to practitioners.

Element B: Reporting to Appropriate Authorities 0.40 points
There is documentation that the organization reports practitioner suspension or termination to the appropriate authorities.

Element C: Practitioner Appeal Process 0.30 points
The organization has an appeal process for instances in which it chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service. The organization informs practitioners of the appeal process.

CR 11: Assessment of Organizational Providers 1.60 points
The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.

Element A: Review and Approval of Provider 0.50 points
The organization's policy for credentialing of health care delivery providers specifies that it:
1. confirms that the provider is in good standing with state and federal regulatory bodies.
2. confirms that the provider has been reviewed and approved by an accrediting body.
3. conducts an onsite quality assessment, if there is no accreditation status.
4. confirms at least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable is reviewed and approved by an accrediting body at least every three years.

Element B: Medical Providers 0.50 points
The organization includes at least the following medical providers:
1. hospitals
2. home health agencies
3. skilled nursing facilities
4. freestanding surgical centers.

Element C: Mental Health and Substance Abuse 0.40 points
The organization includes behavioral health facilities providing mental health or substance abuse services in the following settings:
1. inpatient
2. residential
3. ambulatory.

Element D: Assessing Medical Care Providers 0.10 points

The organization has documentation of assessment of contracted medical health care delivery providers.

Element E: Assessing Behavioral Health Providers 0.10 points

The organization has documentation of assessment of contracted behavioral health care delivery providers.

CR 12: Delegation of CR

If the organization delegates any credentialing activities, there is evidence of oversight of the delegated activity

Element A: Written Delegation Agreement

The written delegation document:

1. is mutually agreed upon
2. describes the responsibilities of the organization and the delegated entity
3. describes the delegated activities
4. requires at least semiannual reporting to the organization
5. describes the process by which the organization evaluates the delegated entity's performance
6. describes the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

Element B: Provisions for PHI

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. a list of the allowed uses of PHI
2. a description of delegate safeguards to protect the information from inappropriate use or further disclosure
3. a stipulation that the delegate will ensure that subdelegates have similar safeguards
4. a stipulation that the delegate will provide individuals with access to their PHI
5. a stipulation that the delegate will inform the organization if inappropriate uses of the information occur
6. a stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

Element C: Right to Approve and to Terminate

The organization retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making. This right is reflected in the delegation document.

Element D: Predelegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation document was signed.

Element E: Annual File Audit

For delegation arrangements in effect for 12 months or longer, the organization has audited files against NCQA standards annually.

Element F: Annual Evaluation
For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

Element G: Reporting
For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element A.

Element H: Opportunities for Improvement
For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been effect, the organization has identified and followed up on opportunities for improvement, if applicable.